

# Disclaimer

The preparation of this report was sponsored by the Idaho Department of Health, Division of Health, Bureau of Clinical and Preventive Services and conducted by Health Systems Research, Inc. (HSR) under the auspices of a contract with the Idaho Department of Health. The report is based upon data provided to HSR by an array of governmental and non-governmental programs in Idaho as well as national data obtained by HSR. HSR is responsible for the report text and the conclusions expressed. The contents should not be interpreted as necessarily representing the official views or policy of the Idaho Department of Health, or the Idaho Government.

---

## Table of Contents

I.	Introduction.....	1
II.	Methodology .....	5
	A. Secondary Data .....	6
	B. Primary Data .....	9
	C. Analysis of Primary and Secondary Data .....	16
	D. Mechanisms for Stakeholder Input and Collaboration .....	17
III.	Idaho Demographics and Family Security.....	20
	A. Population Demographics.....	20
	B. Family Security .....	36
IV.	Idaho Health Care Infrastructure .....	47
	A. Public Sector Health and Wellness System .....	47
	B. Access to Health Information .....	58
	C. Other Health and Wellness Providers .....	60
	D. The Provider Picture .....	68
	E. The Financing Picture .....	70
	F. Data .....	72
	G. Title V .....	73
V.	Pregnant Women and Mothers .....	82
	A. Introduction .....	82
	B. Characteristics of Women in Idaho.....	82
	C. Pregnant Women Outcomes Examined .....	84
	Mothers .....	124

VI.	Infants .....	132
A.	Characteristics of Births in Idaho .....	132
B.	Infants Outcomes Examined .....	136
	Infant deaths.....	143
VII.	Children and Adolescents .....	167
A.	Characteristics of Children and Adolescents.....	167
B.	Child and Adolescent Outcomes Examined.....	170
VIII	CSHCN .....	234
A.	Characteristics of the CSHCN Population.....	234
B.	Outcomes for CSHCN Examined in the Needs Assessment .....	237
C.	Summary Findings and Analysis .....	265
IX	System Collaboration.....	271
A.	Pregnant Women and Infants.....	271
B.	Children and Adolescents .....	274
C.	Children With Special Needs.....	275
D.	Cross-Population Initiatives.....	276
E.	Opportunities for Enhancing System Collaboration .....	278
X	Opportunities for Strengthening Maternal Child Health in Idaho .....	281
A.	Promoting a systems-approach to the planning, organization, delivery and evaluation of MCH services.....	281
B.	Operationalizing a systems-approach to the planning, implementation and delivery of services .....	283

## **Appendices**

Appendix A	Idaho Title V Needs Assessment Key Informant Interview Protocol
Appendix B	Key Results form the Family Health Survey and CSHCN Survey
Appendix C	Idaho Parents of Children Ages 0-8 Focus Group Moderator’s Guide
Appendix D	Bibliography
Appendix E	Performance Measures
Appendix F	Capacity

# CHAPTER I

## Introduction

---

The health of pregnant women, mothers, infants, youth, and children with special health needs is important to the overall well-being of Idaho's families and communities and the State as a whole. Assuring the health of children assures the ongoing health of Idaho. Governor Kempthorne, in declaring this the *Generation of the Child*, reaffirmed that the "children of Idaho are our most precious resources and while they comprise 30% of our population they are 100% of our future" (Office of the Governor, Proclamation *Celebrating Young Americans*, April 2002).

However, assuring the health of Idaho's children and families is not always easy in an ever-changing environment. It is important, therefore, to understand the current health status of these population groups, learn about the factors that promote or impede health and wellness, and use this information to strengthen systems of care and services that families need.

To this end, the Idaho Department of Health and Welfare, Bureau of Clinical and Preventive Services (BOCAPS) contracted with Health Systems Research, Inc. (HSR) to conduct an assessment of maternal, child, and family health in the State. The purpose of the assessment is to gather and present up-to-date information about the health and well-being of the women, infants, children, children with special health care needs, and families residing in the State. The information can be used to guide policies and services to promote the health and well-being of children and families and to facilitate the appropriate and effective allocation of resources.

The assessment was conducted under the auspices of the Federal Title V Maternal Child Health (MCH) Program in accordance with its mandate to the States to conduct an in-depth maternal child needs and capacity assessment every 5 years. The assessment is designed to be useful to all those in Idaho concerned with the health and well-being of the state's mothers, infants, youth, and children with special health care needs.

***Title V focuses on all mothers and children.*** The purpose of Title V is "to investigate and report upon all matters pertaining to the welfare of children and child life among all classes of people" (P.L. 62-116; April 1912). Title V is the *only* Federal legislation dedicated to promoting and improving the health of the Nation's mothers and children. Because of this mandate, it provides a context and overall guidance for all programs that target specific categories of mothers and children and the special problems experienced by these population groups.

The Title V Block Grant Program is a Federal-State partnership that awards funds on a formula basis to State health agencies to meet local needs for the Title V population. Each year, Idaho

receives Federal dollars to promote maternal, child, and family health and well-being in the State. For the effective allocation of these resources, it is critical that State Title V decisionmakers have a thorough understanding of the needs of the MCH population and the capacity of the delivery system to meet these needs. It is for these reasons that it is essential for State Title V Programs to conduct maternal child needs and capacity assessments that are:

- Comprehensive
- Carefully designed
- Multifaceted, using a variety of qualitative and quantitative methodologies to obtain and analyze data
- Respectful of all segments of the maternal child health population groups
- Inclusive, involving stakeholders and families in every component of the process.

***What is a needs and capacity assessment?*** An assessment of the needs of a population group and the capacity of the system to address those needs is fundamentally the description of the gap between “what is” and “what is needed.” However, “need” can be assessed only in relation to the outcomes desired for the population groups being assessed. For example, if a desired outcome in Idaho is early and adequate prenatal care for all pregnant women, then an assessment can be conducted to determine the extent to which pregnant women in Idaho are obtaining early and adequate prenatal care. The process then involves the identification, collection, and analysis of data to determine what prenatal services are provided, to whom, when, and how.

A needs assessment is not simply a data collection exercise but rather a process that uses both qualitative and quantitative methodologies to gather data and examine the relationships among the data. This process results in a comprehensive picture of the population’s status and needs in relation to desired outcomes.

***Maternal child health outcomes form the basis for the assessment framework.*** The assessment framework is anchored by maternal and child health population groups with specific outcomes identified for each group. This outcome approach allows for the organized inclusion of the goals, indicators, and performance measures identified at both the MCH Federal and State levels, permitting us to view them not as isolated, unconnected requirements but rather to see their collective relevancy and utility in improving the health status of the MCH population in Idaho.

These outcomes are stated broadly enough to encompass all the factors that influence their attainment and narrow enough to provide guidance for the assessment process. A framework organized around MCH outcomes helps keep everyone focused on the changes in the health status of the MCH population that are the goals of MCH stakeholders in both the private and public sectors. This design facilitates discussion about the findings and lends itself to the identification of the organizational entities at both the State and local levels that can work with the Title V agency to use the findings for the ongoing improvement of maternal child and family health in Idaho.

The outcomes guiding this assessment were refined by Idaho stakeholders to assure the usefulness of the assessment study and the relevancy of its recommendations. The usefulness of any needs and capacity assessment is directly proportionate to its ability to relay understandable, meaningful, and applicable information to stakeholders and decisionmakers. Moreover, this approach respects the views of stakeholders and fosters their inclusion in the process through the development of a MCH Needs Assessment Advisory Group, and the involvement of stakeholders not only in the process of gathering data but also in the process of determining priorities.

In this assessment, we examine where Idaho is in relation to each outcome, the factors influencing progress toward achievement of the outcome, and the current capacity of the system to provide the services and supports needed to impact the outcomes. The MCH outcomes presented in Table I-1 serve as the framework for the needs assessment and are organized by the Title V population groups. This approach is *inclusive* of the MCH Title V National Performance Measures and the Idaho State Performance Measures and reveals a picture of needs and resources in a structure that all MCH stakeholders throughout can grasp and use readily.

<b>Table I-1.</b> <b>Outcomes for Idaho MCH Population Groups</b>	
<b>1.</b>	<b>Pregnant Women</b> <ul style="list-style-type: none"> <li>• Women of childbearing age use ongoing preventive and primary care appropriately.</li> <li>• Pregnant women use early and adequate prenatal care.</li> <li>• Pregnant women use, as appropriate, the full range of enabling and support services to promote a positive pregnancy outcome.</li> </ul>
<b>2.</b>	<b>Mothers</b> <ul style="list-style-type: none"> <li>• Mothers use comprehensive postpartum services and ongoing primary care.</li> <li>• Mothers use, as appropriate, the enabling and support services needed by them and their families to care for their infants and children.</li> <li>• Mothers have access to breastfeeding information and support as needed.</li> </ul>
<b>3.</b>	<b>Infants</b> <ul style="list-style-type: none"> <li>• Infants are born at term, of normal weight, and without preventable congenital defects.</li> <li>• Very low-birth-weight (VLBW)/preterm infants are born in facilities equipped to care for them.</li> <li>• Infants are welcomed into a family, a home, and a community that is prepared to care for them.</li> <li>• Infants appropriately receive ongoing preventive and primary care.</li> </ul>
<b>4.</b>	<b>Children</b> <ul style="list-style-type: none"> <li>• Children receive ongoing and preventive health care consistent with the <i>Bright Futures</i> Health Supervision Guidelines.</li> <li>• Children are cared for in environments that protect their health, promote their well-being, and ensure their safety.</li> <li>• Families have access to and use services that strengthen their parenting skills appropriately.</li> <li>• Adolescent children use ongoing health services appropriate to their stage of growth and development.</li> <li>• Adolescent children obtain the health and lifestyle information and education that support lifelong positive health behaviors.</li> </ul>

<b>Table I-1.</b> <b>Outcomes for Idaho MCH Population Groups</b>	
<b>5.</b>	<b>Children with Special Health Care Needs (CSHCN)</b> <ul style="list-style-type: none"> <li>• Children with chronic health problems or disabling conditions use all the primary and preventive services used by typical children.</li> <li>• CSHCN use the full range of health-related services needed to maintain or improve their health and well-being and the services to slow, delay, or prevent untoward outcomes resulting from their chronic health conditions or disabilities.</li> <li>• Families of CSHCN, including their siblings, have access to and use appropriately the full range of health and health-related services required to promote their growth and well-being and manage their conditions or disabilities.</li> <li>• CSHCN use out-of-home childcare, preschool, and ongoing educational services as appropriate to their age, developmental stage, and health condition and/or disability.</li> </ul>

**Organization of the Report.** The report is organized as follows:

- Section I – Assessment Methodologies
- Section II – The State Health and Health-related Infrastructure
- Section III – Population Demographics and Family Security Data
- Section IV – Data, Findings, and Analysis by Population Group and Outcomes
  - Section IV A: Pregnant Women and Mothers
  - Section IV B: Infants
  - Section IV C: Children and Adolescents
  - Section IV D: Children with Special Health Care Needs
- Section V – System Collaboration
- Section VI - Needs and Capacity
- Section VI – System Collaboration
- Section VI – Current Performance Measures
- Section VIII – Opportunities
- Section IX – Strategies for Ongoing Assessment

## CHAPTER II

# Methodology

---

As described in the previous section, the needs and capacity assessment is guided by a set of health and well-being outcomes for the MCH population. These outcomes describe what is desired for Idaho's MCH populations, and the information collected will describe “how well” Idaho is meeting each of them.

The Needs Assessment Team used a multifaceted approach to gathering, analyzing, and reporting data and information that included qualitative and quantitative research. Critical to the approach was the development of mechanisms to obtain stakeholder feedback about the findings and opportunities to engage stakeholders in decisionmaking about MCH priorities.

Data collection strategies included:

- Review of existing secondary documents with information and data concerning the status of the health and well-being of pregnant women, infants, children, adolescents, children with special health care needs, and families
- Review of data related to the level of capacity of the providers, programs, and systems that serve these population groups
- Collection of primary data, including key informant interviews, focus groups with families, and a survey containing options tailored to particular subcategories of the MCH population groups (e.g., prenatal, children with special health care needs)
- Analysis of data at the State and regional district levels to examine population needs and the relationships among needs, infrastructure, and services
- Conduct of three regional stakeholder sessions to present assessment findings and seek input into the recommendations
- Organization of an MCH advisory group comprised of stakeholders from community-based organizations, professional associations, BOCAPS, and other Department of Health and Welfare programs
- Collaboration with BOCAPS and other stakeholders (via Web-based efforts and through collaboration with BOCAPS systems partners) to identify internal capacity and MCH priorities.

The ultimate goals of this process, as articulated in the Idaho's Department of Health and Welfare's Strategic Plan, are to improve the health status of the MCH population; to strengthen individuals, families, and communities; and to integrate health and human services.

## A. Secondary Data

Secondary data is information *about* the study group that is gathered, compiled, and reported by others. In the course of this needs assessment, the secondary data sources included health and surveillance data, program data, and survey data. Examples of datasets examined include:

### 1. Vital Records

Records from birth and death certificates are essential in assessing perinatal health, as they are the source for such indicators as low-birth-weight (LBW) and preterm birth rates, infant mortality rates, congenital anomalies identified at birth, and timing of initiation of prenatal care. In general, year 2002 or an average of years 2001- 2003 was used in this analysis.

### 2. Program Data

Programs within the Department of Health and Welfare, local district health departments, and other agencies have information about their clients' risk factors, health status, and use of services that are helpful in creating a picture of MCH needs in Idaho. Family Planning, WIC, Women's Health Check, Oral Health, Children's Special Health Program, and other program data were relied on for this assessment.

### 3. Survey Data

The table below is a summary of the national and State surveys used for this needs assessment.

<b>Table II-1.</b> <b>Youth Risk Behavior Surveillance (YRBS)</b>	
<b>Purpose</b>	<b>Methodology</b>
YRBS monitors six categories of priority health risk behaviors among children and young adults—behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infection; unhealthy dietary behaviors; and physical inactivity—plus overweight.	Students complete the self-administered questionnaire during one class period and record their responses directly on a computer scannable questionnaire booklet or answer sheet. Before the survey was conducted, local parental permission procedures were followed.



<b>Table II-1.</b> <b>Youth Risk Behavior Surveillance (YRBS)</b>	
<b>National Survey on Children with Special Health Care Needs</b>	
<b>Purpose</b>	<b>Methodology</b>
<p>The primary goal of this survey is to assess the prevalence and impact of special health care needs among children in all 50 States and the District of Columbia. This survey explores the extent to which CSHCN have medical homes, adequate health insurance, and access to needed services. Other topics include care coordination and satisfaction with care.</p>	<p>More than 3,000 households with children were screened in order to identify 750 children with special needs in each State. Interviews were conducted with their parents. Also, brief health insurance interviews were conducted for children without special needs to estimate State-level health care coverage using equivalent-sized samples in each State. Finally, for uninsured children from low-income households, questions about parents' awareness of and experience with Medicaid and the State Children's Health Insurance Program (SCHIP) were asked.</p>
<b>Pregnancy Risk Assessment Monitoring System (PRAMS)</b>	
<b>Purpose</b>	<b>Methodology</b>
<p>PRAMS is a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments. PRAMS collects State-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy. Thirty-one states and New York City currently participate in PRAMS. Four other states previously participated. This survey is used for national comparisons.</p>	<p>The PRAMS sample of women who have had a recent live birth is drawn from the State's birth certificate file. Each participating State samples between 1,300 and 3,400 women per year. Women from some groups are sampled at a higher rate to ensure adequate data are available in smaller but higher risk populations. Selected women are first contacted by mail. If there is no response to repeated mailings, women are contacted and interviewed by telephone. Data collection procedures and instruments are standardized to allow comparisons among States.</p>
<b>Pregnancy Risk Assessment Tracking System (PRATS)</b>	
<b>Purpose</b>	<b>Methodology</b>
<p>A survey of new mothers regarding mothers' experiences before, during, and after pregnancy. It provides information on the intendedness of pregnancy, prenatal care, health behaviors, breastfeeding patterns, and other issues.</p>	<p>The PRATS methodology is the same as the PRAMS methodology described above. The window of response is 3-12 months postpartum.</p>

<b>Table II-1. Youth Risk Behavior Surveillance (YRBS)</b>	
<b>Behavioral Risk Factor Surveillance System (BRFSS)</b>	
<b>Purpose</b>	<b>Methodology</b>
BRFSS is a health survey of adults in Idaho and includes information about health behaviors (such as alcohol use or cancer screenings), chronic diseases like diabetes, and health care access issues.	The BRFSS is conducted as a random telephone survey of the noninstitutionalized adult population. In order to produce health district estimates, Idaho's sample has grown in size from 600 people in 1984 to approximately 4,900 beginning in 1997. The survey is administered in every month of the calendar year. After annual data collection is complete, individual responses are weighted to be representative of the state's adult population and analysis is performed on the weighted data.
<b>Idaho Substance Use, School Safety, and School Climate Survey</b>	
<b>Purpose</b>	<b>Methodology</b>
The goal of this survey is to evaluate middle and high school students' use and avoidance of alcohol, tobacco, and other drugs; their experiences with substance use education; as well as their perceptions of the school environment, safety issues such as driving under the influence of intoxicants.	This survey used a stratified random method to select at least 625 students of six grade levels. For each grade level, schools in each of the six state regions were randomly sampled. All students in selected schools were invited to participate. Students and their parents were provided with information about the study to allow them to make an informed, voluntary decision to participate. The survey was first administered in 1998 and since been administered every 2 years.
<b>Idaho State Smile Survey</b>	
<b>Purpose</b>	<b>Methodology</b>
The Smile Survey is designed to collect statewide data on the oral health of young children in Idaho. Specifically, the survey measures the prevalence of decayed, missing and filled teeth, preventive and restorative needs, and use of sealants.	The Idaho State Smile Survey is conducted once every 5 years on a representative sample of kindergarten, 3rd-grade, and 6th-grade students.
<b>School Health Policies and Programs Study (SHPPS)</b>	
<b>Purpose</b>	<b>Methodology</b>
SHPPS is a national survey that evaluates school health policies and programs at the State, district, school, and classroom levels. Only State level data was used in the current report. The survey focused on eight school health program components: health education, physical education and activity, health services, mental health and social services, food service, school policy and environment, faculty and staff health promotion, and family and community involvement.	State-level data was collected by self-administered questionnaires were mailed to designated respondents in state education agencies in all U.S. States and D.C. In cases of missing data, respondents were followed up with additional mail and telephone communication.

<b>Table II-1.</b> <b>Youth Risk Behavior Surveillance (YRBS)</b> <b>School Health Education Profile Survey (SHEPS)</b>	
<b>Purpose</b>	<b>Methodology</b>
SHEPS monitors trends in school health education topics, including sex, substance use, and injury prevention as well as health education staff training.	One type of questionnaire was administered to school principals to assess school health and environment policies. Another type of questionnaire was administered to lead health education teachers to assess health education instruction. Both questionnaires were mailed to 222 secondary public schools in Idaho containing any of grades 6 through 12 during the spring of 2002.

Data from these and other sources, including past needs assessments from various organizations, were gathered and cataloged in relation to the specific indicators and outcomes to present a complete picture of each MCH or CSHCN population group's needs.

## **B. Primary Data**

Primary data are information directly gathered from the study group. HSR used the examination of secondary data to guide the collection of primary data. The combination of both primary and secondary data completes the picture of MCH population needs and of the status of the delivery system.

A combination of qualitative and quantitative research methods was used to gather the primary data needed. These methods included:

- Key-informant interviews
- Surveys
- Focus groups

It is important to utilize qualitative primary data in the assessment because it permits access to information that is important but not necessarily quantifiable. In short, primary qualitative data can fill out the MCH picture with real-time information and help to put a “face” on the story.

### **1. Interviews with Key Informants**

As described above, interviews with key informants—State officials, providers, health care purchasers, other public-sector stakeholders, and advocates—provided critical qualitative information on the health needs within the State, effectively completing the outline described by the analysis of existing quantitative data. Forty-nine (49) interviews took place over the course of 5 months. The table below describes the types of service providers interviewed.

<b>Table II-2.</b>	
<b>Key Informants by Type:</b>	<b>Number</b>
Direct Service Providers (e.g., hospital birth educator, certified nurse-midwife, school nurse, etc.)	11
Community-based Direct Service Organizations Program Directors (e.g., Migrant Health Council, Parents as Teachers, Head Start, etc.)	9
Medicaid Staff	7
State-level IDHW Program Directors	8
Regional Health and Welfare Directors	3
District Health Office Directors or Program Managers	7
Advocacy Group Directors (e.g., March of Dimes, Idaho Parents Unlimited, etc.)	4

In these interviews, we addressed issues such as:

- The major MCH risks and needs seen by informants in the course of their work
- Services available to address these needs
- Barriers to access to care
- Potential reasons for the persistence of risk factors, health problems, and access barriers affecting specific MCH populations.

To assure the consistency and comparability of information gathered from various sources, the interviews were conducted using structured protocols. To ensure that all relevant issues were covered in the interview, while still allowing room for the expression of individual opinion and experience, the interview guide was designed with unstructured, predominantly open-ended questions. The interview guide is presented in Appendix A.

Following the interviews, summaries were developed that synthesized critical information gathered. Data collected in these interviews was triangulated with data from other sources and examined for consistency.

In addition to the one-on-one interviews, HSR also facilitated a group discussion among participants of the Idaho Perinatal Conference. The title of the hour-long session was *Speaking Out: What Do YOU Think About Maternal Child Health Issues and Needs in Idaho?* The purpose of that discussion was to assess participants' experiences and perceptions regarding screening, referrals, followup care, and other perinatal issues. Approximately 40 health practitioners and policymakers attended the session.

## **2. Surveys to Address Gaps in Data**

Although it is important to learn about MCH needs from the viewpoint and experiences of health care policymakers and providers, it is essential to go directly to the consumers of MCH services

to learn their views and perceptions of MCH needs and experiences using the service delivery system. This is a source of data that does not go through the filter of MCH officials and offers insights that simply cannot be gained through other means. Two methods were used to obtain these data: surveys and focus groups.

The needs assessment team conducted two convenience sample surveys. One was a general Family Health Survey, and one was specific for Families of Children with Special Health Care Needs. These surveys provided a snapshot of the needs and issues confronting families. The surveys also gave families an opportunity to provide structured input into the MCH Needs Assessment process beyond the focus group participation. The survey questions were evaluated through pretests of the survey.

Families could access the Family survey in two ways. A paper version was available through District Health Offices, Parents as Teachers, and the Infant-Toddler Program. The survey was also available online. Members of the MCH Advisory Group, key informants, and other contacts were asked to alert families to the Web site and survey.

The results of the survey are limited to self-selected participants, and not generalizable to all of Idaho. We were not able to capture the needs of people who are currently not accessing services, or do not read English. The surveys were at a ninth-grade reading level in English. Access to the survey required a family to have connections to the health and social system. Unless the family received a paper-based survey, they needed Internet service to complete the Web-based version.

Seven hundred and three (703) families completed the Family Health Survey. Over half of the respondents received or learned about the survey through the District Health Office. Over 90% of respondents lived in Idaho for more than 2 years, and 79% having lived in their city or town of residency for more than 2 years. Most respondents were married (66%) and had a household income of under \$30,000 (67%). Most children had either Medicaid (45%) or Private Insurance (42%); only 7% did not have any health insurance. Additional data is highlighted in Appendix B.

The tables below show where respondents learned about the survey and their demographic characteristics.

<b>Table II-3. Demographic Information of Respondents for Family Health Survey</b>		
	<b>N=703</b>	
<b>Demographic</b>	<b>Number</b>	<b>Percent</b>
<b>Location Where Respondent Received or Learned of Survey</b>		
District Health Office	406	59%
Parents as Teachers	68	10%
Regional Health and Welfare	31	4%
Head Start/Early Head Start	34	5%
Other	151	22%
<b>District</b>		
District 1	112	16%

**Table II-3.  
Demographic Information of Respondents for Family Health Survey**

	<b>N=703</b>	
<b>Demographic</b>	<b>Number</b>	<b>Percent</b>
District 2	102	15%
District 3	24	3%
District 4	192	28%
District 5	17	2%
District 6	220	32%
District 7	26	4%
<b>Age</b>	<b>Number</b>	<b>Percent</b>
<18 Years Old	14	2%
18-30	390	55%
31-50	269	38%
>50	30	4%
<b>Gender</b>	<b>Number</b>	<b>Percent</b>
Male	39	6%
Female	660	94%
<b>Lived in City/Town of Residence</b>	<b>Number</b>	<b>Percent</b>
Under 2 Years	146	21%
2 to 5 Years	158	23%
6 to 10 Years	115	17%
11 to 15 Years	71	10%
Over 15 Years	204	29%
<b>Years in Idaho</b>	<b>Number</b>	<b>Percent</b>
Under 2 Years	49	7%
2 to 5 Years	81	12%
6 to 10 Years	86	12%
11 to 15 Years	97	14%
Over 15 Years	382	55%
<b>Number of Children</b>	<b>Number</b>	<b>Percent</b>
1	233	35%
2	204	30%
3	125	19%
4+	108	15%
<b>Children's Health Insurance</b>	<b>Total</b>	<b>Percent</b>
CHIP	96	7%
Medicaid	643	45%
No Health Insurance	101	7%
Private	598	42%
<b>Health Coverage for Self</b>	<b>Total</b>	<b>Percent</b>
Yes	456	66%
No	232	34%
<b>Marital Status</b>	<b>Total</b>	<b>Percent</b>
Single, Never Married	102	15%
Married	455	66%

<b>Table II-3. Demographic Information of Respondents for Family Health Survey</b>		
	<b>N=703</b>	
<b>Demographic</b>	<b>Number</b>	<b>Percent</b>
Divorced	68	10%
Separated	26	4%
Member of Unmarried Couple	39	6%
Widowed	2	0%
<b>Household Income</b>	<b>Total</b>	<b>Percent</b>
Under \$10,000	165	25%
\$10,001-\$20,000	163	24%
\$20,001-\$30,000	122	18%
\$30,001-\$40,000	80	12%
\$40,001-\$50,000	43	6%
\$50,001-\$65,000	51	8%
>\$65,000	49	7%

One hundred and twelve (112) families with children with special health care needs completed the CSHCN survey. The Children's Special Health program and the Infant-Toddler program were the locations where most respondents learned of the survey. Respondents were asked to indicate the primary insurance for their children with special health care needs (if they had more than one child, they were to indicate for the child with the most medically complicated needs). Just under half (45 percent) of the children had health insurance through the parent or guardian's employer, and 38 percent had Medicaid. The table below describes additional demographic characteristics.

<b>Table II-4. Demographic Information of Respondents for Children's Special Health Care Needs Survey</b>		
	<b>N=112</b>	
<b>Demographic</b>	<b>Number</b>	<b>Percent</b>
<b>Location Where Respondent Received or Learned of Survey</b>		
IPUL	3	3%
Infant-Toddler Program	38	35%
Family Voices	0	0%
Children's Special Health Program	40	37%
School	2	2%
Other	26	24%
<b>Number of Children</b>	<b>Number</b>	<b>Percent</b>
1	25	23%
2	29	27%
3	30	28%
4+	25	24%

<b>Table II-4. Demographic Information of Respondents for Children's Special Health Care Needs Survey</b>		
	<b>N=112</b>	
<b>Children's Health Insurance</b>	<b>Total</b>	<b>Percent</b>
Private Insurance Through Employer	49	45%
Private Insurance Paid by Self	7	6%
Medicaid	41	38%
Katie Beckett	4	4%
Children's Health Insurance Program	5	5%
No Health Insurance	3	3%
<b>Household Income</b>	<b>Total</b>	<b>Percent</b>
Under \$10,000	7	6%
\$10,001-\$20,000	15	14%
\$20,001-\$30,000	23	21%
\$30,001-\$40,000	15	14%
\$40,001-\$50,000	15	14%
\$50,001-\$65,000	16	15%
>\$65,000	11	10%

### **3. *Focus Groups to Obtain Information from the MCH Population Groups on MCH Needs and Experiences Obtaining Services***

Guided focus group discussions have been shown to illuminate issues and answer research questions in more depth than individual interviews because participants within focus groups often respond to ideas and opinions presented by other group members, thereby stimulating a richer set of responses and ideas. Focus groups also are a respectful way of obtaining information from consumers without using forms or surveys that may be off putting. In general, focus groups provide access to people's perceptions in a way that may not be otherwise obtainable.

The focus group facilitators were not based in the State and thus were less likely to be seen by consumers and other stakeholders as having any "hidden agendas" and more as an unbiased group whose goal is to learn about the experiences, beliefs, and concerns of the consumers about MCH issues. Research questions focused on learning about services members of the various MCH population groups have sought and why, what their experience has been in accessing services, and what needs were unmet or inadequately met. The moderator guides are in Appendix C.

HSR analyzed the focus groups using a transcript-based analysis of findings that involved the development of a coding scheme that allowed the project team to assign codes to predominant themes and subthemes of the group discussions.

HSR conducted eight focus groups in several regions of the State. Below is a description of the number of participants by location.



<b>Table II-5.</b> <b>Focus Group Participant By Site of Group</b>	
Focus Group Participants	Number of Participants
<b>Parents of Young Children</b>	
• Caldwell (Conducted in Spanish)	10
• Orofino	10
• Pocatello	9
• Bonners Ferry	7
<b>Parents of Children with Special Needs</b>	
• Twin Falls	8
• Idaho Falls	6
<b>TOTAL Parents</b>	<b>50</b>
<b>Latino Adolescents</b>	
• Nampa	9

<b>Table II-6.</b> <b>Demographic Information of Focus Group Participants</b>		
Demographic	Number (N=50)	Percent
<b>Number of Children</b>		
1	9	18%
2	15	30%
3	14	28%
4	6	12%
5	4	8%
7	1	2%
8	1	2%
<b>Health Insurance for Children</b>		
Yes	38	76%
No	5	10%
Some Children Have, Some Don't	5	10%
N/A	2	4%
<b>Health Insurance for Self</b>		
Yes	30	60%
No	10	20%
N/A	10	20%
<b>Income</b>		
Under \$10,000	8	16%
\$10,001-\$20,000	9	18%
\$20,001-\$30,000	7	14%
\$30,001-\$40,000	6	12%
\$40,001-\$50,000	6	12%
\$50,001-\$65,000	5	10%
>\$65,000	8	16%

<b>Table II-6. Demographic Information of Focus Group Participants</b>		
<b>Demographic</b>	<b>Number (N=50)</b>	<b>Percent</b>
N/A	1	2%
<b>Race/Ethnicity</b>		
White	36	72%
Hispanic	13	26%
American Indian	1	2%
<b>Last Grade Completed</b>		
Less than High School	5	10%
High-school Graduate	6	12%
Some College	16	32%
Associate's Degree	4	8%
Bachelor's Degree	11	22%
Graduate or Professional Degree	6	12%
N/A	2	4%

The following table displays the demographic information for the nine Latino adolescent participants:

<b>Table II-7. Demographic Information for Latino Focus Group</b>	
<b>Demographic Information</b>	<b>Number</b>
<b>Age</b>	
14	2
15	5
16	2
<b>Health Insurance</b>	
Yes	4
Don't know	4
No	1
<b>Saw a Doctor in the Last 12 months</b>	
Yes	7
No	2

## C. Analysis of Primary and Secondary Data

The analysis of both secondary and primary data was structured to permit the examination of the relationships between groups, their needs, and the infrastructure, programs, and capacity in place to address them. The analysis was conducted on a State level—in order to get a “big” picture—but also was conducted on a regional or district level. This analysis will allow for planning for MCH activities at both levels of the health infrastructure system. An important aspect of this task

is the analysis of supportive, complementary, or contradictory data. Because all the secondary data was collected for alternate purposes by different groups with varying levels of rigor, it was analyzed to determine how well it fits together. Data was classified by population, location, collection methodology, and how recent the data was collected.

An analysis of the relationship between needs and infrastructure or services also was conducted. A critical part of the work accomplished under this needs assessment is learning what gaps exist. This critical gap analysis takes the assessment well beyond the documentation of numbers of people with particular issues and moves into other significant areas. These include what types of infrastructure and services are in place to address those needs, who is involved, where there is excess capacity, and where there is insufficient capacity. This analysis permits BOCAPS and its partners to know where intervention efforts are most needed and to develop a concrete plan to work toward the closing of gaps. The analysis examines the size of populations, the location of populations, the services and infrastructure in locations that are appropriate to the population, and finally the differences between the two.

## **D. Mechanisms for Stakeholder Input and Collaboration**

Central to the needs assessment was engaging Idaho stakeholders in the process. The involvement of MCH Advisory Group, the Capacity Assessment for the State Title V (CAST-5) Team, and stakeholder meeting participants was critical to this process. These input mechanisms enabled us to:

- Gather additional data and reports
- Understand the story behind the numbers
- Provide opportunities for feedback and suggestions
- Assess the impact and feasibility factors to be considered in establishing priorities
- Determine potential audiences for the assessment findings and distribution mechanisms
- Begin to develop a plan to implement recommendations.

Below is a description of the role of the stakeholder meetings, Advisory Group, and CAST-5 Team in the assessment process.

### **1. *MCH Advisory Group***

To assure that the assessment truly met the needs of Idaho, HSR developed an Idaho MCH Needs and Capacity Assessment Advisory Group to provide advice, guidance, and “reality checks” to the process. Because they become invested in the process via membership in the Advisory Group, the stakeholders involved in this group were also extremely helpful in disseminating findings and promoting implementation of priorities.

## **2. *Capacity Assessment for State Title V (CAST-5)***

An important element of this assessment is the analysis of the internal capacity of the Division of Health. This was conducted using the CAST-5 Tool developed by the Association of Maternal and Child Health Programs (AMCHP) and the Women's and Children's Health Policy Center at The Johns Hopkins University.

CAST-5 participants included BOCAPS managers, including program directors and other key personnel, representatives from other key Bureaus such as Health Promotions and Health Policy and Vital Statistics, and several other stakeholders who work closely with the Division of Health and could speak to the impact that capacity and State policies have on the broader community.

Although CAST-5 focuses on the State Title V Program, MCH and MCH-related activities also take place in programs outside of Title V. This means that the CAST-5 process produced information that is useful within the context of larger systems and system assessments.

Participants in CAST-5 were asked to self-assess the Division of Health's performance of MCH essential services by rating the adequacy of specific process indicators. The CAST-5 assessment also included components to determine specific resources or capacity needs and to identify strengths, weaknesses, opportunities, and threats associated with the essential services. Synthesis of results of the self-assessment process provided the basis for developing an action plan to address priority needs for enhancing capacity.

## **3. *Stakeholder Meetings***

Three meetings were conducted in three different regions of the State; namely Coeur d'Alene, Boise, and Pocatello. To better assure representation of all significant stakeholders in each of the meetings, the meetings were publicized to community-based organizations, professional associations, consumer and other organizations, BOCAPS programs and constituents, and all key informants. At these meetings, HSR staff described the purpose of the needs and capacity assessments, how the study was conducted and how the information could be used. A discussion of the preliminary findings then followed that included the solicitation of any additional information meeting attendees may have regarding needs and capacity issues.

### **Recommend MCH/CSHCN Priorities to Target Efforts for Improvement**

There are many steps involved in reaching decisions about priorities and many factors to consider in the decision making process. First and foremost, it is important to gather information about the unmet and inadequately met needs of the MCH population and the capacity both available and required to meet these needs. This is the function of the Title V needs assessment: to provide the BOCAPS and its systems partners with the most current and reliable information that is gathered from an array of sources using multiple methodologies. This information allows those charged with making decisions about the allocation of limited resources to begin the process informed about current and projected needs and capacities. This is the information that HSR will provide to BOCAPS in this report.

Clearly it is important to obtain as clear, comprehensive, and well-documented an assessment of unmet and inadequately met needs and of existing capacity as possible to inform the prioritization process. However, need cannot be used in isolation to determine priorities and subsequently drive effective resource allocation. Many other factors are involved in the process of identifying priorities and include the level of public awareness, attitudes, and concerns about the issue. Issues of greater societal concern are more likely than lesser-known issues to be placed on the political agenda. Other factors affecting priority setting include the “doability factor.” Questions to raise about “doability” include: Can something realistically be done about the need? Are there resources available to address the need? If this need is addressed and resources allocated to it, what other needs will remain unmet? If we can mobilize resources to address a need, will our efforts have a meaningful impact? How do we define meaningful impact in terms of the numbers of people affected, opportunities to prevent subsequent problems, the perceived burden of the need on the individual, the community, society as a whole?

The questions raised above must be addressed by Idaho MCH decisionmakers and stakeholders. It is the role of HSR to provide the stakeholders with as much information as possible in formats that are readily understandable and to assist the stakeholders in the priority-setting process. Several strategies were used by HSR accomplish this, including:

- Stakeholder feedback sessions
- Use of an Idaho MCH Needs Assessment Web site
- Collaboration with MCH systems partners.

The overall strategy regarding dissemination and discussion of the needs assessment findings, recommendations, and priorities was to identify and build on the resources currently in place in Idaho. This serves a twofold purpose. First, it is a cost-effective way to reach as many stakeholders as possible; and second, it facilitates the involvement and investment of a range of stakeholders in promoting MCH in Idaho, helping them to internalize the notion that “MCH is everybody’s responsibility.”

## Chapter III

### Idaho Demographics and Family Security

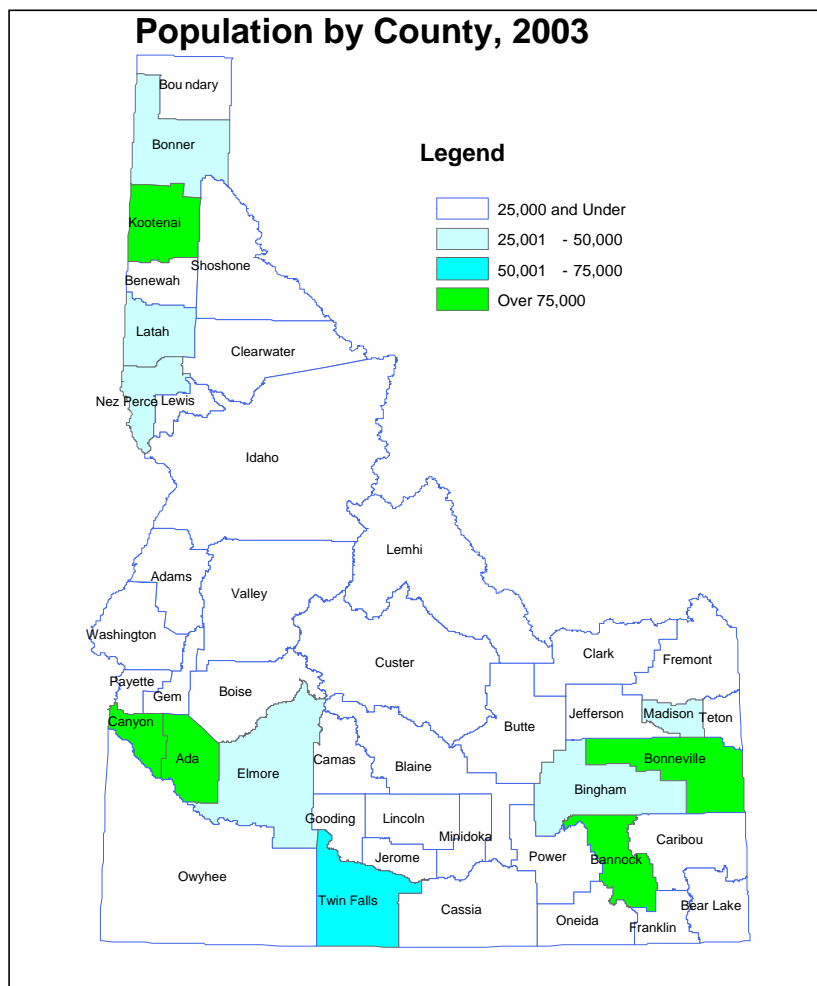
---

This section of the report contains an overview of population demographics and a description of several family security issues important to maternal, child, and family health.

#### A. Population Demographics

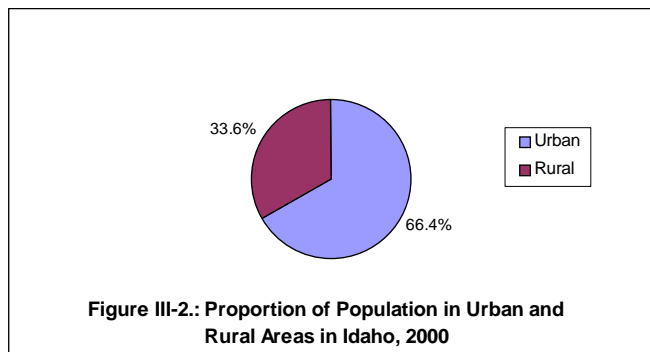
##### Population Density

The population in Idaho has increased nearly 36 percent, from 1,006,749 in 1990 (Idaho's Health, 1999) to 1,366,332 in 2003 (Population Division, 2004). The most populous counties include Kootenai, Canyon, Ada, Bonneville, and Bannock, each of which has over 100,000 people. However, nearly 75 percent of the Idaho's counties have fewer than 25,000 people (Figure III-1). A third of Idaho's population resides in rural areas, a much greater proportion than the national average (Figure III-2). In addition, about 3 percent of Idaho's land area was defined as frontier in 2000. Idaho also ranks 8th in the nation for its disproportionately high number of people that reside in frontier counties. In 1997, the Frontier Education Center adopted a consensus definition of "frontier" based on a matrix of population density, distance in miles, and travel time in minutes from a market-service area. This definition has since been adopted by the National Rural Health Association and the Western Governor's Association. Based on this definition, 19.4 percent, or 243,664 individuals, resided in frontier area during 2000 (Frontier Education Center, 2004). The following map displays population numbers by county followed by a chart describing the rural or urban population distribution.

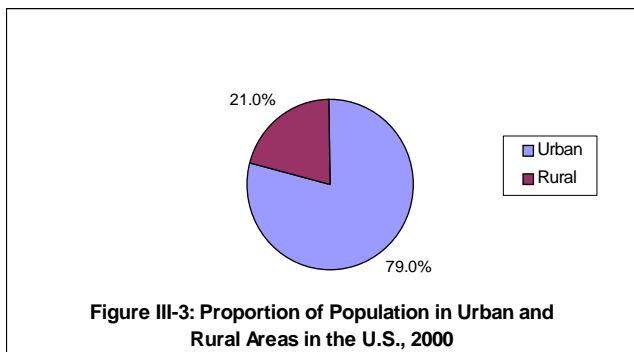


**Figure III-1: Population distribution by county in Idaho, 2003**

Source: Population Division, 2004



Source: Population Division, 2001



Source: Population Division, 2001

## Population Groups by Age and Gender

Nearly a third of Idaho's population are children, and about a quarter of the children were under the age of 5 during 2002 (Table III-1). The counties with the greatest proportion of children under age 19 are concentrated in the southern part of the State. Counties with over 35 percent children include Clark, Fremont, Bingham, Power, Cassia, Franklin, and Bear Lake (Figure III-4). One third of the population are adults between the ages of 20 and 44, and the remaining third are over the age of 45. The age distribution in Idaho was similar among males and females during 2002 (Table III-1).

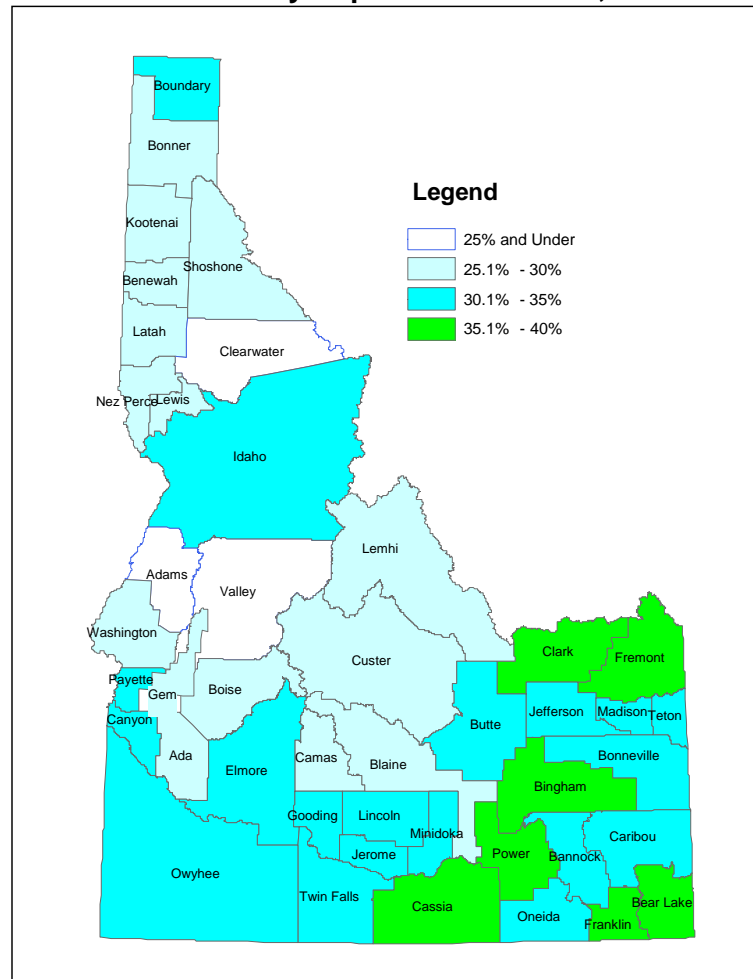
**Table III-1.**  
**Distribution of Idaho's Population by Age and Sex, 2002**

Age Group	Female		Male	
	<i>n</i>	%	<i>n</i>	%
All Ages	669,186	100	671,945	100
0-19:	202,047	30.2	213,238	31.7
<5	48,695	7.3	51,255	7.6
5-19	153,352	22.9	161,983	24.1
20-44	230,878	34.5	239,591	35.7
>45	236,261	35.3	219,116	32.6

Source: Idaho Department of Health and Welfare, 2004



### Percent of County Population Under 19, 2002



**Figure III-4: Distribution of Population Under Age 19 by County, 2002**

Source: Idaho Department of Health and Welfare, 2004

### Population Groups by Race and Ethnicity

Idaho's non-Hispanic White population has decreased from 94 percent in 1990 to 92 percent in 2003, while all other racial and ethnic groups experienced an increase during this time (Table III-2). The population group that has experienced the greatest increase is Hispanics, who now comprise 8.3 percent of the population. Hispanics are largely concentrated in the southern counties. Counties with greater than 20 percent Hispanics include Owyhee, Clark, Jerome, Cassia, and Oneida (Figure III-5).

The second largest racial or ethnic minority group is American Indian, accounting for 1.8 percent of Idaho's population in 2003 (Table III-2). The American Indian population is concentrated in

the reservations and population centers that comprise Idaho's six American Indian tribes: 1) Kootenai, 2) Coeur d'Alene, 3) Nez Perce, 4) Shoshone Paiute, 5) Shoshone Bannock, and 6) Northwest Band of Shoshoni Nation (Idaho Department of Health and Welfare [IDHW], 2004). Counties with greater than 4 percent American Indians include Bingham, Nez Perce, and Lewis (Figure III-5). Asians and Pacific Islanders represented 1.5 percent of Idaho's population in 2003 while Blacks represent just .57 percent. (Table III-2).

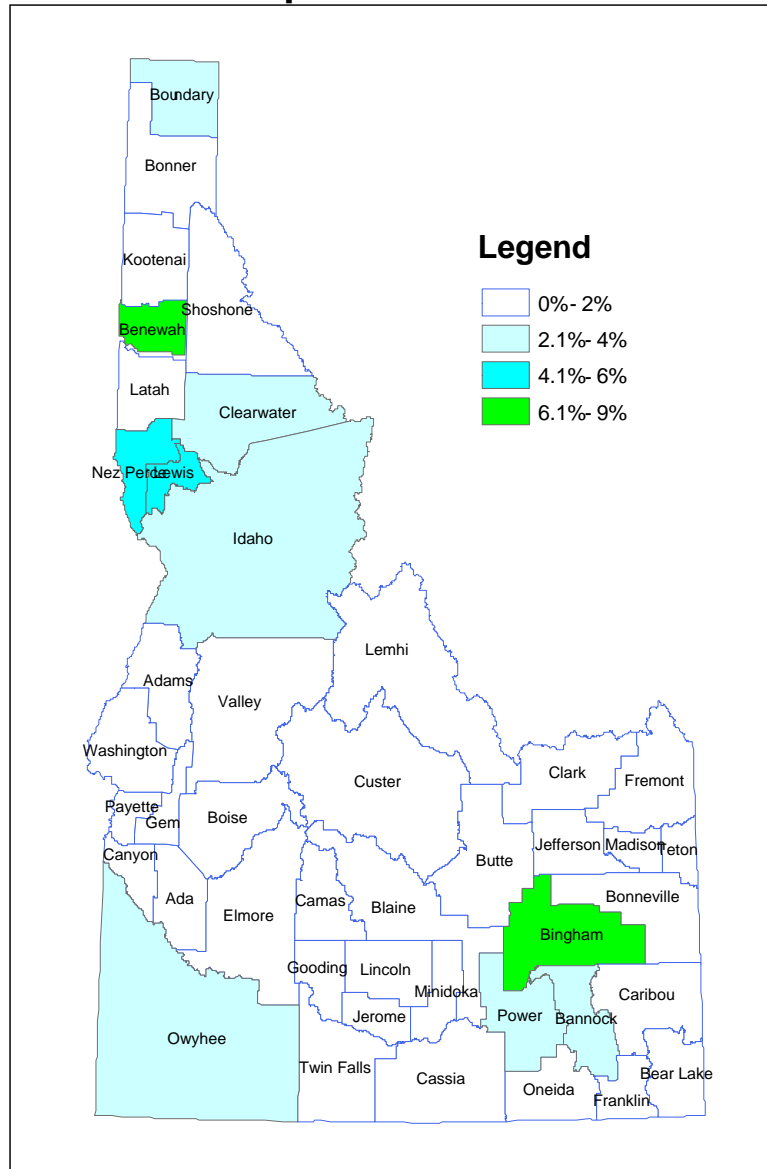
**Table III-2: Distribution of Idaho's Population by Race and Ethnicity, 2003**

Race/Ethnicity	1990		2003	
	<i>n</i>	%	<i>n</i>	%
Total	1,006,749	100	1,333,165	100
White	950,451	94.4	1,231,240	92.4
Black	3,370	0.3	7,661	0.57
American Indian	13,780	1.4	24,042	1.8
Asian/Pacific Islander	9,365	0.9	20,040	1.5
Hispanic, Any Race	52,927	5.3	110,604	8.3

Sources: 1990 data is from the Population Division (2001) and 2003 data is from the Population Division (2004)

The following maps display the distribution of American Indian and Hispanic residents by county.

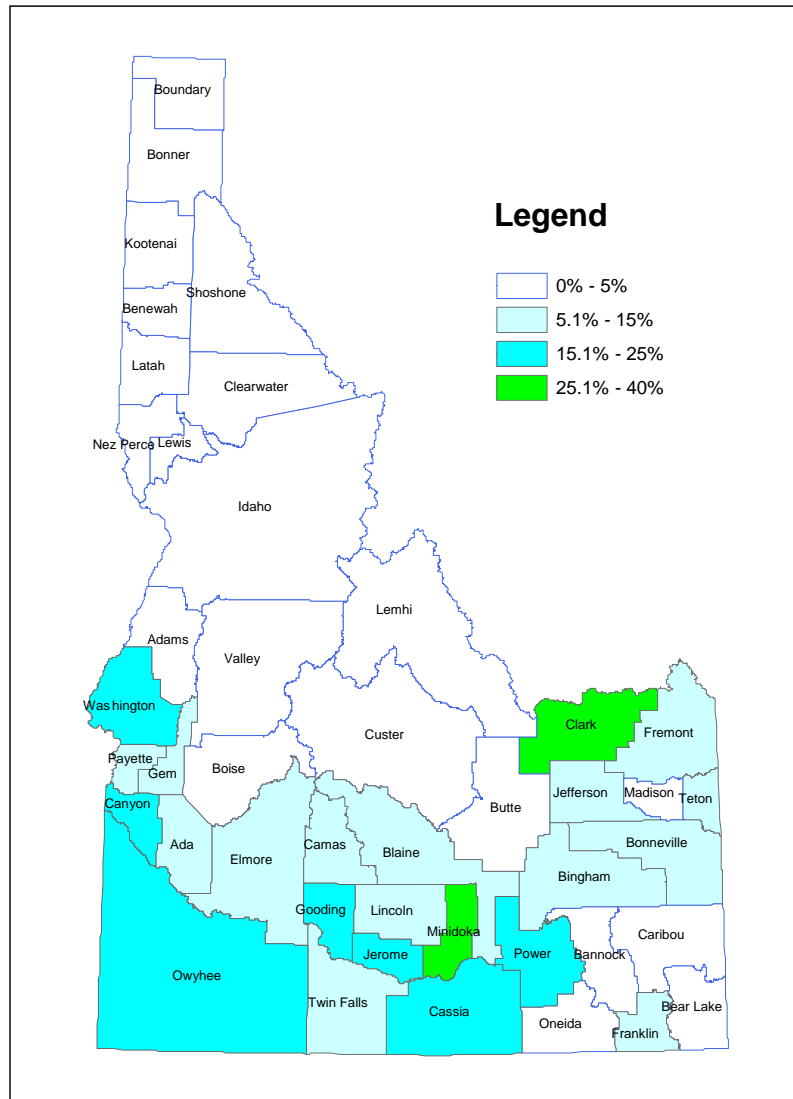
## Percent of Population: American Indian



**Figure III-5: Distribution of American Indian Population in Idaho by County, 2002**

Source: Idaho Department of Health and Welfare, 2004

## Percent of Population: Hispanic



**Figure III-6: Distribution of the Hispanic Population in Idaho by County, 2002**

Source: Idaho Department of Health and Welfare, 2004

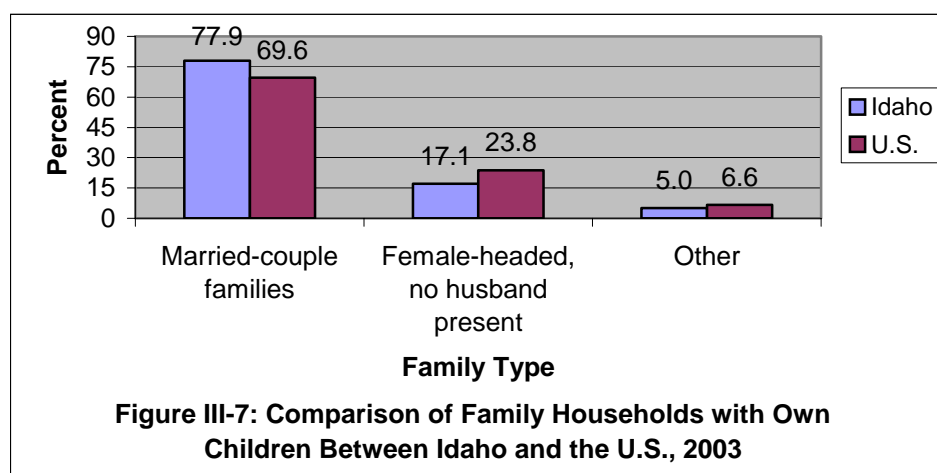
## Household Composition

There were 503,145 households in Idaho during 2003. About 72 percent of these households were comprised of families, a slightly higher proportion than all U.S. households (Table III-3). Family households in Idaho were more likely to be headed by married couples and less likely to be headed by single females than the national average (Figure III-7).

**Table III-3: Comparison of the Distribution of Household Types Between Idaho and the U.S., 2003**

Household Type	Idaho		U.S.	
	<i>n</i>	%	<i>n</i>	%
Total Households:	503,145	100	108,419,506	100
Family:	360,170	71.6	73,057,960	67.4
Non-family	142,975	28.4	35,361,546	32.6

Source: Population Division, 2004



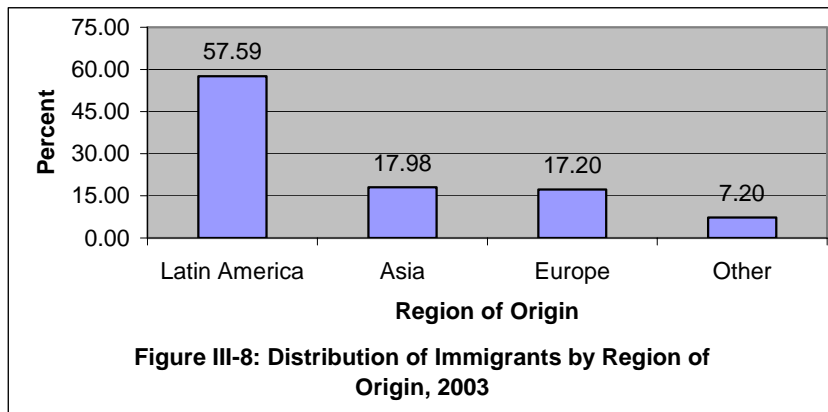
Source: Population Division, 2004

## Country of Birth and Preferred Language

Nearly 6 percent of Idaho's population was foreign born in 2003; only about a third of those foreign born were U.S. citizens (Table III-4). The majority, 66 percent, were recent immigrants that entered the country after 1990. Almost three times as many immigrants came from Latin America compared to all other regions (Figure III-8). Many immigrants in Idaho have difficulty speaking English. Asian and Pacific Island language speakers had the greatest difficulty speaking English, while other Indo-European language speakers had the least difficulty (Figure III-9). Counties with the highest proportion of individuals over age 5 that speak 2 or more languages and speak English less than very well include Clark, Owyhee, Gooding, and Minidoka (Figure III-10).

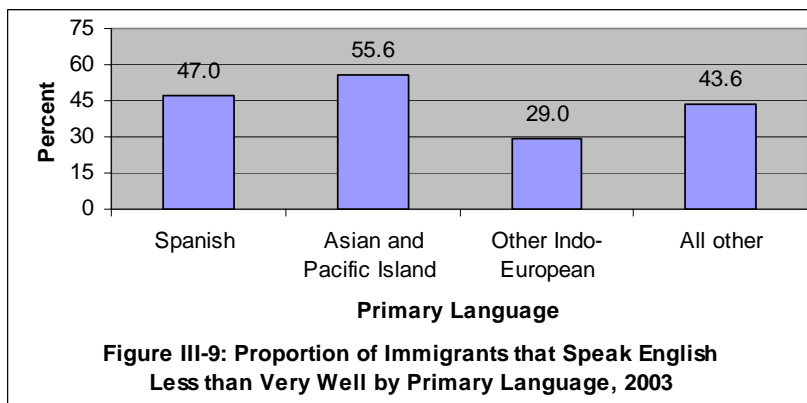
**Table III-4: Characteristics of Idaho's Immigrant Population, 2003**

<b>Characteristics</b>	<b>n</b>	<b>%</b>
Total Population:	1,333,165	100
Foreign Born:	78,739	5.9
Naturalized Citizen	25,206	32.0
Not a Citizen	53,533	68.0
Entered 1990 or Later	51,957	66.0
Entered Before 1990	26,782	34.0



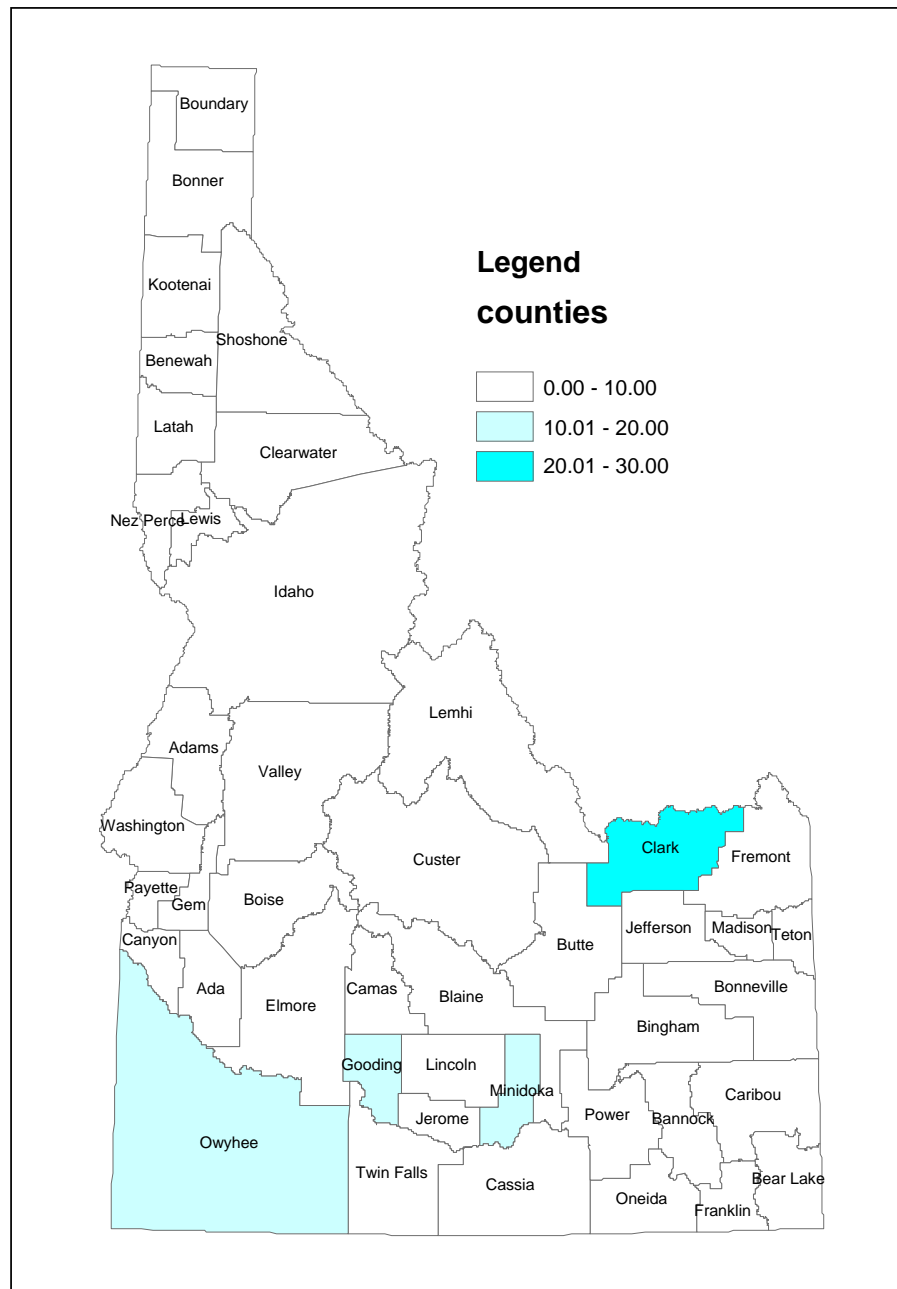
Source: Population Division, 2004

The following figure displays the percent of immigrants in Idaho who speak English less well than they speak their primary language.



Source: Population Division, 2004

## Percent of Population: English Proficiency



**Figure III-10: Distribution Population over Age 5 that Speak 2 or More Languages and Speak English “Less than Well,” 2000**

Source: Population Division, 2001

## Income

Idaho’s median household income during 2001-2003 was \$40,230, which was lower than both the Region X average of \$45,941 and the U.S. average of \$43,527 (DeNavas-Walt et al., 2004). Idaho’s population also earned less than all Americans across all types households and

individuals in 2003. This regional income disparity was greatest among family households and female, full-time, year-round workers (Table III-5). Nearly two-thirds of Idaho's counties earned less than \$35,000 per household in 1999. Counties with the lowest earning households include Shoshone, Idaho, Adams and Owyhee (Figure III-11).

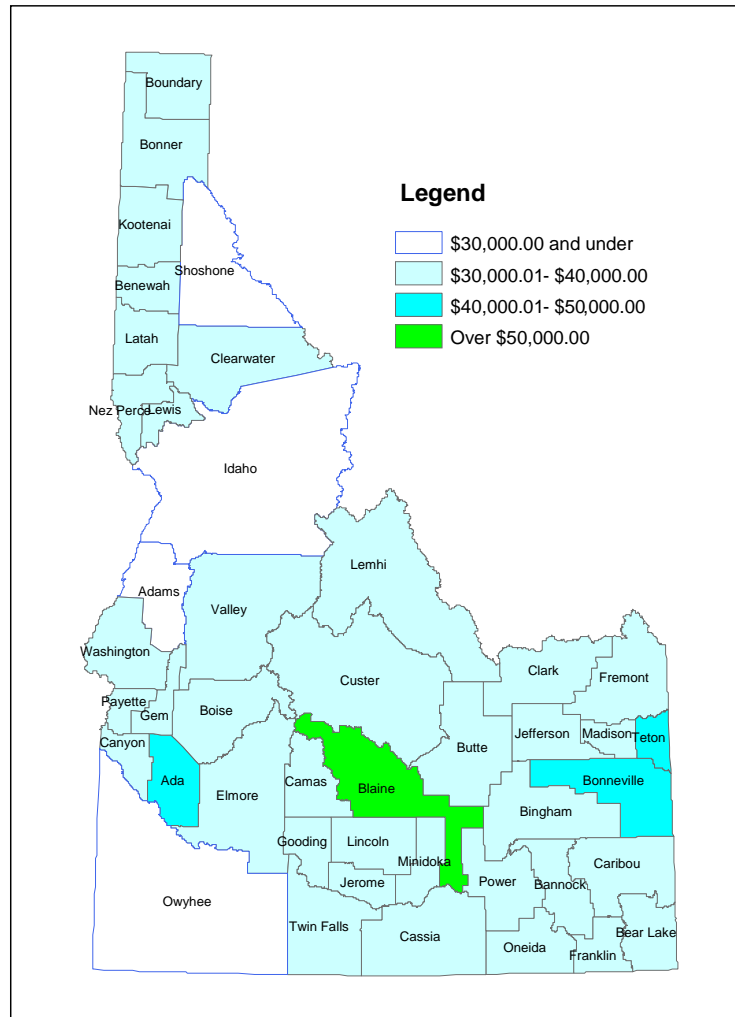
**Table III-5: Comparison of Median Household Income Among Different Types of Households and Individuals Between Idaho and the U.S., 2003**

<b>Type of Household or Individual</b>	<b>Idaho</b>	<b>U.S.</b>	<b>Difference</b>
All Households:	\$39,492	\$43,564	-\$4,072
Family	\$46,783	\$52,273	-\$5,490
Non-family	\$22,854	\$26,341	-\$3,487
Male, Full-time, Year-round Workers	\$35,171	\$40,456	-\$5,285
Female, Full-time, Year-round Workers	\$25,119	\$30,507	-\$5,388

Source: Population Division, 2004



## Median Household Income, 2002



**Figure III-11: Distribution of Median Household Income by County, 1999**

Source: Population Division, 2001

### Poverty Levels

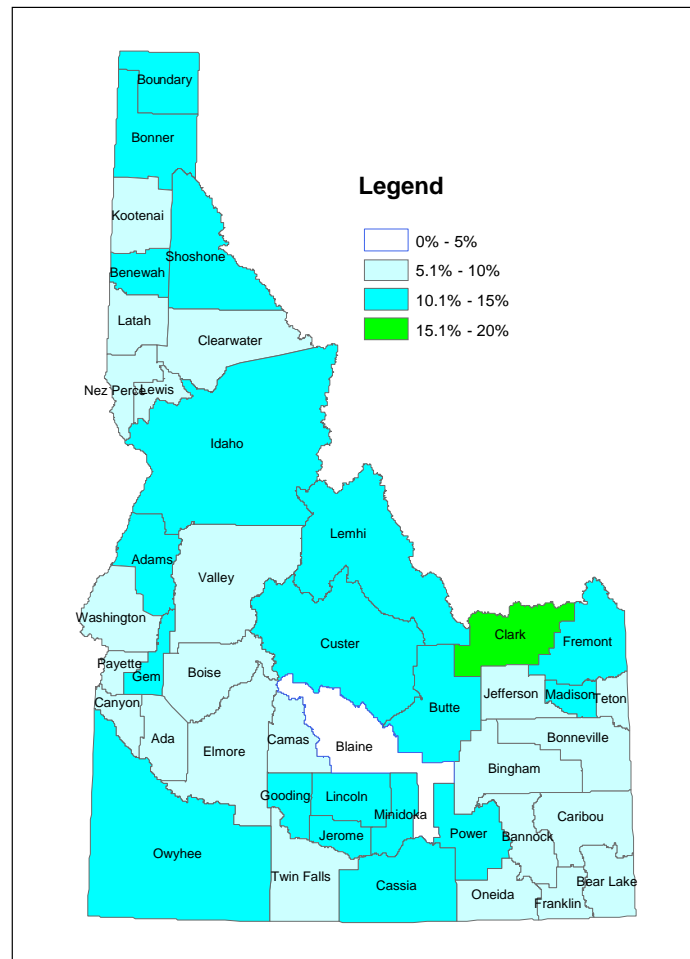
The proportion of people in poverty in Idaho was 11.0 percent during 2001-2003, which was comparable to Region X range (9.0-11.7 percent) and slightly below the national average of 12.1 percent (DeNavas-Walt et al., 2004). Young children under age 5 experienced the most poverty in Idaho, about 19 percent compared to just 12 percent compared to adults age 18 and older (Table III-6). The burden of poverty is experienced in most regions of state. Just one county, Blaine, has fewer than 5 percent of populations living below the FPL. About 44 percent of counties have over 10 percent of their populations living in poverty, with one county with over 15 percent of its population in poverty, Clark.

**Table III-6: Comparison of the Proportion of Different Types of Individuals Living Below the FPL Between Idaho and the U.S., 2003**

Type of Individual	Idaho	U.S.
All Individuals	13.9%	12.7%
Related Children Under Age 5	19.3%	20.5%
Related Children Ages 5-17	16.1%	16.1%
Adults Age 18 and Older	12.3%	11.0%

Source: Population Division, 2004

### Percent of Families in Poverty



**Figure III-12: Distribution of Families Living Below the FPL, 1999**

Source: Population Division, 2001

There are also racial and ethnic disparities in poverty rates in Idaho. The poverty rate for Hispanics was 37 percent compared to just 11 percent among whites during 2002-2003. This is an even higher proportion of Hispanics living below the FPL than the national average, 30 percent (Kaiser Family Foundation, 2005). Idaho's American Indian population has also experienced a disproportionately high burden of poverty. Nearly a quarter of Americans Indians lived below the FPL in 2000 (Turner, 2004).

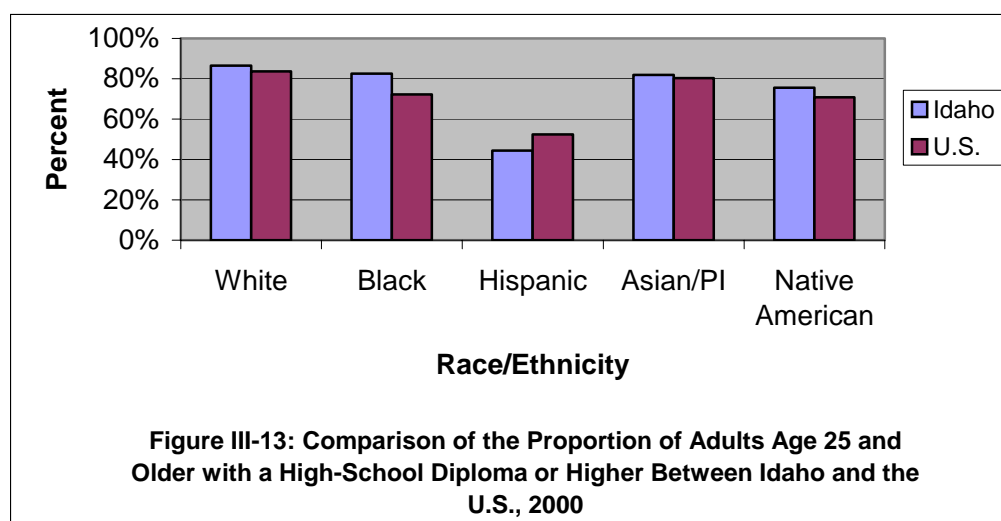
## Educational Levels

Just 12 percent of Idaho's adults age 25 and older had less than a high school diploma or equivalent in 2003, representing a lower proportion than the national average. In addition, Idaho's adults were also much more likely to have completed some college than the U.S. (Table III-7). There was a significant amount of variation in educational attainment among racial and ethnic groups in Idaho. Adults in all racial and ethnic groups, except for Hispanics, were slightly more likely than the national average to have a high school diploma or greater. Fewer than half, 44 percent, of Hispanic adults completed high school in 2002, an even lower proportion than the national average, 52 percent (Figure III-13). A smaller proportion of Idaho's adults had a bachelor's degree or higher across most racial and ethnic groups. This proportion was smallest among American Indians, 9.5 percent, and Hispanics, 6.6 percent (Figure III-14).

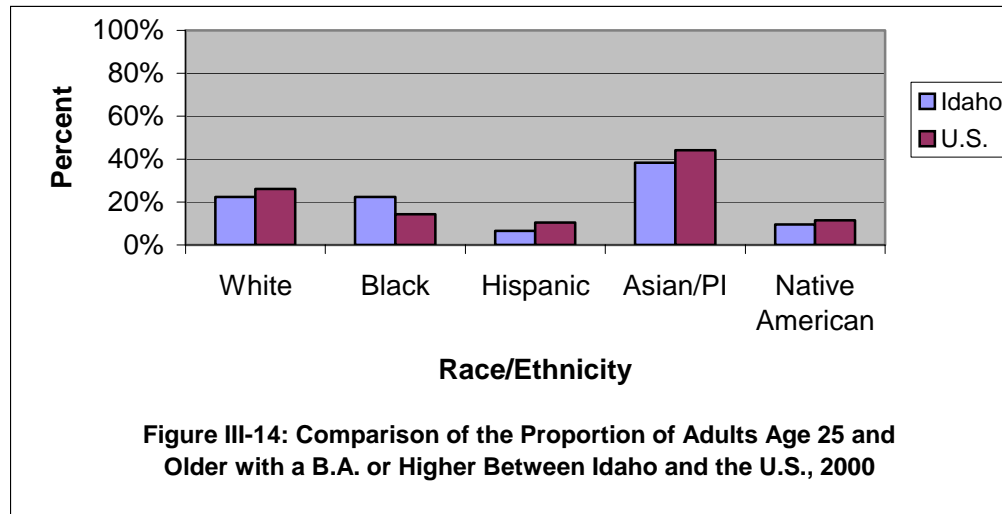
**Table III-7: Comparison of the Education Attainment of Individuals Age 25 and Older Between Idaho and the U.S., 2003**

<b>Educational Attainment</b>	<b>Idaho</b>	<b>U.S.</b>
Less than High-School Graduate	12.1	16.4
High-School Graduate (Including Equivalency)	29.6	29.8
Some College, No Degree	26.1	20.3
Associate Degree	8.1	7.0
Bachelor's Degree or Higher	24.0	26.5

Source: Population Division, 2004



Source: Synder et al., 2004



Source: Synder et al., 2004

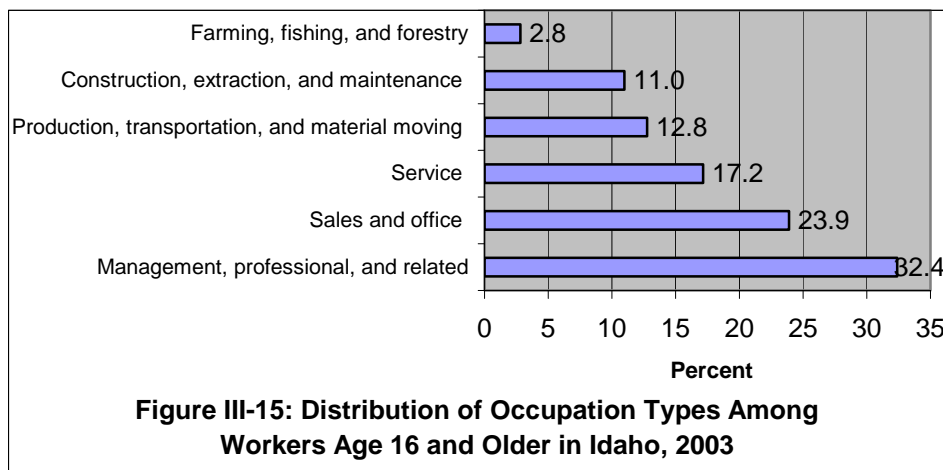
## Employment

The majority of individuals over age 16 participated in the labor force, the majority in the civilian occupations, in 2003. Similar to the U.S., about 15 percent fewer females than males participated in the labor force. Idaho's unemployment rate was lower than the national average among both males and females, 6.6 percent and 7.1 percent respectively (Table III-8). The plurality of workers, nearly a third, were employed in management, professional, and related industries, followed by the sales industry, 24 percent. Just 3 percent of workers were employed in farming, fishing, and forestry industries (Figure III-15). The self-employment rate, or the proportion of all employed people who have their own businesses, was 23 percent in Idaho, compared to 18 percent in the U.S. during 2002. Idaho currently ranks fourth in the nation for its relatively high self-employment rate (Northwest Area Foundation, 2005).

**Table III-8: Comparison of Employment Status of Individuals Age 16 and Older Between Idaho and the U.S., 2003**

Employment Status	Idaho		U.S.	
	Females	Males	Females	Males
In Labor Force	60.1	74.6	59.0	73.5
Civilian Labor Force	99.9	99.4	99.9	99.3
Employed	92.9	93.4	92.4	92.3
Unemployed	7.1	6.6	7.6	7.7
Not in Labor Force	39.9	25.4	41.0	26.5

Source: Population Division, 2004



Source: Population Division, 2004

## Summary

Idaho's population is increasing significantly particularly in the southern part of the State along the Snake River. However, large areas of Idaho are sparsely populated with Idaho ranking eighth in the nation for the high number of people that reside in frontier counties.

Nearly one-third of Idaho residents are children and almost 25 percent of children are under the age of 5 years. Again the southern area of the state accounts for the majority of residents under the age of 19 years. The non-Hispanic White population in Idaho has decreased somewhat from 1990 to 2003; however, the vast majority of Idaho residents are non-Hispanic White. Hispanics comprise a growing proportion of the population (8.3 percent) and are largely concentrated in the southern section of the State. Nearly 6 percent of Idaho's population was foreign born in 2003, and a third of those foreign born were U.S. citizens. Many immigrants report difficulty speaking English. American Indians account for almost 2 percent of Idaho's population and are concentrated in the reservations and population centers that comprise Idaho's 6 American Indian tribes.

The majority of households in Idaho are headed by married couples. Idaho's median household income was \$40,230 during 2001-2003, lower than both the regional and overall national averages. Young children in Idaho experience the most poverty in Idaho with overall poverty levels fairly consistent across the State. Racial and ethnic disparities are, however, present in Idaho with a poverty rate of 37 percent reported for Hispanics compared to 11 percent for whites. Nearly 25 percent of Idaho's American Indian population live below the poverty level. There are also racial and ethnic disparities in educational levels with Hispanics reporting lower educational attainment levels than Whites. Overall Idaho's unemployment is below the national average. Idaho ranks fourth in the nation for its relatively high self-employment rate.

This demographic information provides a context for the subsequent discussion of family security issues in Idaho.

## B. Family Security

Infants, children, and adolescents thrive in families where they feel a sense of security and belonging. There are numerous studies linking parenting practices with parental employment, income and poverty, education level, family structure, and parental psychological well-being and supports. Addressing these socioeconomic factors requires a broad range of service strategies. Moreover, it requires a system where each service provider builds on their strengths and where the needs of the family are met holistically, promptly, and effectively (Morrill, 1992).

There are many components of family security, and the following are examined in this assessment:

- Economic security
- Housing security
- Food security
- Health care access security

Also included is a description of what parents say they need to care for their families and what is currently available in Idaho to address these needs.

### 1. *Economic Security*

To adequately care for infants, children, and adolescents, the adults in their lives must have a source of income that can adequately meet the needs of Idaho's youngest citizens. The 2004 Federal poverty guidelines designate a family of four with a gross yearly income of \$18,850 as living in poverty. Fifteen percent or 71,921 families in Idaho report incomes under \$35,000. Data for the year 1999 and reported in the 2000 Census, reveal that approximately 7.1 percent of Idaho's 470,133 households earned less than \$15,000; another 15.3 percent earned less than \$25,000. An additional 15 percent of households reported incomes less than \$35,000.

According to the *2004 Job Gap Study Report* commissioned by the Northwest Federation of Community Organizations (NWFCO), a budget of \$38,081 or \$18.31 per hour is required in Idaho to provide a family of 4 with a decent and safe standard of living (Northwest Federation of Community Organizations and Sommers, 2004)). Currently in the State, a full-time head of household earning minimum wage (\$5.15) has a gross income of \$10,712 or \$8,138 below the Federal poverty level. The Study reported statewide averages but stressed that in some areas of the State costs are higher (particularly for housing and childcare) and, as a result, living wages are higher.

While Idaho's overall unemployment rates remained fairly steady throughout the 1990s, during 2001, the number of unemployed persons increased by 18.1 percent. The National Center for Children in Poverty (2005), using 2001-2003 data from the Current Population Survey, reported that 93 percent of low-income children had parents who were employed full or part time or part of the year as opposed to a national average of 83 percent.

<b>Table III-9.</b>			
	<b>Low-income Children: Parental Employment</b>		
	<b>Employed Full-time/Year-round (Parent Who Works Most)</b>	<b>Employed Part-year or Part-time (Parent Who Works Most)</b>	<b>No Parent Employed</b>
National			
	55%	28%	17%
Idaho	94,274	50,240	10,302
	61%	32%	7%

Source: National Center for Children in Poverty, 2005. (Note: Data calculated from the Annual Social and Economic Supplement (the March supplement) of the Current Population Survey from 2002, 2003, and 2004, representing information from calendar years 2001, 2002, and 2003. NCCP averaged 3 years of data because of small sample sizes in less-populated States. The national data were calculated from the 2004 data, representing information from calendar year 2003. )

Department of Labor projections from 1998 to 2008 estimate that jobs requiring only on-the-job training and that pay a living wage comprise the top 10 “declining occupations” in Idaho. The indication is that without a degree or other professional training, it will become increasingly difficult to earn a living wage in Idaho. The NWFCO study found that for each job opening in Idaho, regardless of pay, there are two job seekers on average. Each job opening that pays at least the \$18.82-an-hour living wage attracts on average 10 job seekers (Hall, 2004).

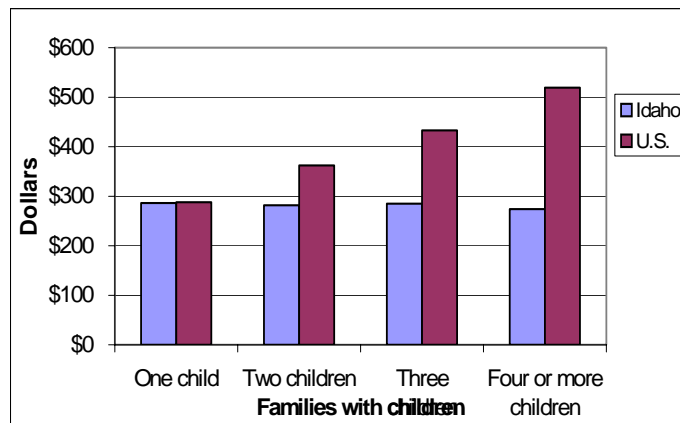
Most publicly funded programs in Idaho administered by the State are limited to families with children. This includes Idaho’s Temporary Assistance to Needy Families (TANF) program, referred to as Temporary Assistance for Families in Idaho (TAFI). While the earnings limit for receiving TAFI is low compared to TANF programs in neighboring States, it is in the middle range (Idaho ranks 29<sup>th</sup>) for all States and Territories. Idaho’s program includes a maximum monthly family cap of \$309 regardless of the number of persons in the household, mandatory 2-year lifetime limit, strict work requirements, treatment of vehicles over \$4,650 as assets, and extremely limited access to training programs. Idaho is one of 5 States that require women with infants to meet work requirements once the child turns 12 weeks (Office of Family Assistance, 2002).

There are also very limited work exceptions available in Idaho. In the focus groups with families of children with special health care needs, one of the parents reported that she was a TAFI recipient who needed to stay home to take care of her critically ill child. She indicated that it was extremely difficult to obtain a work exemption and that she has been told that she will not be given an exemption to the 2-year time limit. TAFI benefits do not continue for children after the family reaches the lifetime limit (Idaho Housing and Finance Association and Idaho Department of Commerce, 2000). Table III-10 displays the TANF applicant earnings limits and maximum benefit for a family of three in Idaho and three contiguous States.

<b>Table III-10. Applicant Earnings and Monthly Maximum Benefits for Idaho and Three Contiguous States – TANF (2002)</b>		
<b>State</b>	<b>Applicant Earnings Limit for 1-parent Family of 3</b>	<b>Monthly Maximum Benefit for Family of 3</b>
<b>Idaho</b>	<b>\$7,766 per Year</b>	<b>\$309</b>
<b>Montana</b>	<b>\$10,512 per Year</b>	<b>\$507</b>
<b>Washington</b>	<b>\$13,104 per Year</b>	<b>\$546</b>
<b>Wyoming</b>	<b>\$6,480 per Year</b>	<b>\$340</b>

Source: National Center for Children in Poverty, 2005 (Note: analysis of Gretchen Rowe with Victoria Russell, *The Welfare Rules Databook: State Policies as of July 2002*, Assessing the New Federalism, The Urban Institute, 2004)

It is important to note that while other States increase the monthly benefit for family size, Idaho has a family cap of \$293 so benefits do not increase with family size (Figure III-16).



**Figure III-16: Comparison of Average Monthly Amount of Cash Assistance Between TANF Programs in Idaho and the U.S. (October 2000-September 2001)**

Source: Office of Family Assistance, 2002

A combination of the State's stringent policies and a State culture that discourages the receipt of public assistance combines to limit the number of families who receive cash assistance. According to the National Center for Children in Poverty (NCCP), the percentage of low-income children who receive TANF is lower in Idaho than in any other State. NCCP reports that only 5 percent of low-income children in Idaho receive TANF, compared to 12 percent nationally (Koball and Douglas-Hall, 2004). Idaho's TANF caseload declined 90 percent between the passage of Federal welfare reform in August 1996 and September 2001. Only Wyoming had a larger decline. Idaho's decline is even larger in magnitude when one considers Idaho's rapid population growth. While there has been a recent increase in the caseload, TAFI continues to cover only a small portion of the low-income population.



## 2. *Housing Security*

As the nation's fifth fastest-growing State during the 1990s, Idaho's housing market expanded in almost all areas of the State. Of 527,824 housing units in April 2000, over 23 percent were constructed during the 1990s. Assuming a continuation of population trends, Idaho would need to fill or build approximately 8,500 new housing units each year to accommodate projected households (Idaho Housing and Finance Association and Idaho Department of Commerce, 2000).

However, given the costs of building and rehabilitating housing and an increase in demand for housing that has exceeded supply, the price of housing has been pushed up faster than incomes can increase (Idaho Housing and Finance Association and Idaho Department of Commerce, 2000). Large numbers of households are burdened by the high cost of housing relative to their incomes. Many of these families are housed in substandard or overcrowded units, while others are homeless. According to the Idaho Housing and Finance Association's analysis of 2000 Census data, 4,438 housing units in Idaho lacked complete plumbing facilities and 3,232 units lacked complete kitchen facilities (Idaho Housing and Finance Association, 2001).

The standard for housing affordability adopted by the Federal Government is that households should pay no more than 30 percent of income to meet their housing costs. Households that pay more than 30 percent of their income for housing are considered "housing cost burdened" and those that pay more than 50 percent are considered "severely cost burdened." As income increases, households are generally able to afford more and better housing. Table III-11 describes the percent of housing burden by Region in Idaho.

<b>Table III-11. Housing Cost Burden – Idaho 2001</b>		
<b>Region</b>	<b>Housing Cost Burdened</b>	<b>Severely Cost Burdened</b>
I	33.5%	15.2%
II	33.0%	18.8%
III	26.5%	11.0%
IV	23.1%	9.0%
V	30.5%	14.7%
VI	28.5%	12.1%
VII	34.9%	15.5

Source: Idaho Housing and Finance Association, 2001

A federally sponsored rental housing choice voucher program designed to assist very low-income families to afford safe and sanitary housing in the private market is referred to as Section 8 Housing. Housing vouchers are administered locally by public housing agencies (PHA) that receive Federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program. There are 10 PHAs in Idaho. Eligibility for the program is

determined by the PHA based on the annual gross income and family size and is limited to U.S. citizens and special categories of noncitizens who have eligible immigration status. Table III-12 provides some data about the utilization of the Section 8 program in Idaho. The number of recipient households with children increased from 1998 to 2000 but the spending per household decreased in that same period.

<b>Table III-12.</b> <b>Idaho Section 8 Rental Housing Vouchers</b>									
	# of Recipients *			# of Recipient Households with Children		Total Spending on All Households (Federal Dollars in Millions)		Spending per Household per Year	
	2004	2000	1998	2000	1998	2000	1998	2000	1998
<b>ID Total</b>	6,093	5,384	4,844	3,360	3,342	\$19.9	\$21.0	\$3,696	\$4,332
Region X Averages	18,582	14,461	13,658	8,234	7,866	\$67.6	\$69.5	\$4,545	\$5,076

\* Figure includes households with and without children. Nationally, about 60 percent of vouchers go to households with children; Idaho reported 63 percent of vouchers to households with children in 2002.

Source: National Center for Children in Poverty, 2005b

To better understand Idaho's housing conditions the Idaho Housing and Finance Association (IHFA) conducted a survey of housing units under the Section 8 certificate and voucher program in mid-1999. Section 8 housing is representative of the modest housing stock in each housing market studied. The worst housing conditions were found in Wallace, Lewiston, Orofino, Grangeville, McCall, and Mountain Home. Other areas with documented severe need for housing rehabilitation include certain neighborhoods in North Nampa, Garden City, and central Pocatello (Idaho Housing and Finance Association, 2001).

Another resource available to support adequate housing for families is the LIHEAP Energy Assistance Program that includes weatherization, heating system repairs and energy costs. This program is administered by the Community Action Agencies. These six agencies are organized into an association know as The Community Action Partnership Association of Idaho and are active in a range of activities to assist low-income families.

## Special Populations

In recent years, there has been a significant increase seen in the number of families experiencing homelessness. Data collected via IHFA's Homeless Tracking System (HTS) indicated that in 1997 families with children comprised 40 percent of the total homeless population served by homeless service providers. However in 1999, 68 percent of the homeless served were members of families. In Idaho, single-parent families headed by women were at the highest risk for homelessness with 62 percent of homeless families comprised of single women with children, 35 percent were comprised of two parents with children, and 3 percent were single men with

children. There is a network of six Community Action Agencies (CAAs) using resources from the Federal Community Services Block Grant to assist identified homeless clients ((Idaho Housing and Finance Association, 2001). The CAAs are also involved in other housing programs designed to promote home ownership.

As one of the least urbanized states in the nation, Idaho's low population density makes it impractical and cost prohibitive to develop shelter facilities with supportive services in every community. Transportation to larger communities is often not available and families are often reluctant to leave whatever support system they currently may have in the smaller communities. In rural Idaho, people who are homeless are more likely to live in a car or camper, with friends or relatives or in substandard housing. The Five-Year Strategic Plan for Housing and Community Develop recommends that the definition of homelessness be expanded in rural States such as Idaho to include persons who lack permanent housing and are living double up with friends.

While 76 percent of the homeless in Idaho are classified as non-Hispanic White, an examination of the homeless population in Idaho reveals that there is an over-representation of both Hispanic persons and African Americans who are homeless. Persons of African American decent make up 0.5 percent of the general population and 1 percent of the homeless population. Hispanic persons make up 7 percent of the general population but 11 percent of the sheltered homeless population (Idaho Housing and Finance Association, 2001).

These numbers probably underestimate the number of persons of Hispanic descent that experience homelessness in Idaho because migrant workers, who are predominately Hispanic, are extremely vulnerable to homelessness and are less likely to seek services through traditional homeless shelters due to language and cultural factors. Subpopulations of homeless include women and children who may be fleeing domestic violence.

Migrant and seasonal farm workers are often at considerable risk for inadequate housing. Extreme poverty caused by very low-wage jobs, low educational attainment, short-term jobs, and long distances between migratory jobs makes it difficult for farm workers to commit to the 6-month lease required in most housing markets. Farm-worker families also experience discrimination and are vulnerable to exploitation by opportunistic landlords.

Interestingly, IHFA reports that most of the telephone calls to their housing hotline come from single mothers with one or more children with a majority indicating that their financial hardship could be alleviated if they received their regular court-ordered child support or alimony. The report states that in many cases, these women are working one or more low-paying jobs and feel that since they do not receive public assistance, the State is slow (at best) to pursue deadbeat dads for child support owed (Idaho Housing and Finance Association, 2001).

### **3. *Food Security***

Food security, defined as access by all people at all times to enough food for an active, healthy life, is one of several conditions necessary for a family to be healthy and able to care for its members. Food insecurity occurs whenever the availability of nutritionally adequate and safe

foods or the ability to acquire acceptable foods is limited or uncertain. Hunger is defined as the unpleasant or painful sensation caused by a recurrent lack of food.

A report developed by the Economic Research Service of USDA on food security and using CPS data for the years 1995-2003 revealed that overall households with children reported food insecurity at more than double the rate for households without children. Among households with children, those with married-couple families showed the lowest rate of food insecurity. Children living with a single mother were more affected by resource-constrained hunger, as were Black and Hispanic children. Regionally, the prevalence of food insecurity was higher in the South and West than in the Northeast and Midwest. In Idaho, 13.7 percent of households were identified as food insecure (with or without hunger) in comparison with an overall national rate of 10.8 percent. The difference between the Idaho and national rates was reported as statistically significant (Sullivan and Eunyoung, 2002).

The Idaho Community Action Network (ICN) surveyed 134 low-income families to assess their ability to provide healthy meals to their families. Although the sample is small, the survey findings indicate the need for further investigation of the issues and the seriousness of food insecurity for many low-income families. The survey found that:

- Close to 60 percent of the families surveyed could provide 3 balanced meals only 3 times per week
- More than half indicated that they did not have enough money to buy food to last for an entire month
- 72 percent of adults and 40 percent of children using food stamps reported eating less or skipping meals due to a lack of available food
- Nearly all families reported difficulties applying for the Food Stamp Program
- Almost all families reporting using hunting and fishing as a source of food, indicated that they could not afford the licenses and tags required (Hall, 2001).

Those who responded to the survey are families sufficiently connected to the system to obtain a survey. Families not connected in any way to the system may have even higher levels of food insecurity.

The Food Stamp Program is intended to provide a basic safety net with the goal of alleviating hunger and malnutrition by permitting low-income households to obtain a more nutritious diet through normal channels of trade. Eligible families receive a debit card that can be used instead of cash to purchase food items. The amount of Food Stamps provided is based upon monthly income. Idaho applicants are asked to complete a 4-page application and participate in an interview with a caseworker before a decision about benefits can be made. Applicants must provide their social security card or other residency documents; proof of income; recent bank statements; value of vehicles owned; proof of stocks, bonds, life insurance, etc.; proof of identity; and proof of child care costs if any. If the applicants' monthly income is less than \$150 and assets are less than \$100, or monthly income plus assets is lower than housing and utility costs, or someone in the household is a migrant or seasonal worker, eligibility may be approved

within 7 days of application. The following Table displays the average number of food stamp recipients by State region and statewide for the years 1998 and 2002.

<b>Table III-13. Average Monthly Number of Food Stamp Recipients. 1998 and 2002</b>								
Health and Welfare Regions	I	II	III	IV	V	VI	VII	Statewide
1998	9,649	5,362	12,481	11,741	6,723	9,209	6,883	8,864
2002	11,378	5,414	15,572	13,739	7,787	10,615	7,932	10,334

Source: Substance Abuse Social Indicators, 2004

The maximum food stamp benefit for a family of 3 is \$371 per month. In FY 2002, 36,000 children were program recipients. Only 34 percent of households with children with incomes less than 130 percent of the poverty level were enrolled in the program in 2002 (National Center for Children in Poverty, 2005a).

USDA's Food and Nutrition Service (FNS) calculates State-by-State participant access rates (PARs) for the Food Stamp Program. The PARs measure the extent to which low-income people are participating in the food stamp program. Idaho's participation rate for 2003 was 62.5 percent and ranked as 28<sup>th</sup> in overall state participation rates. The U.S. average participation rate is 61.5 percent. Implementation in 1997 of the 1996 welfare law had many unintended, adverse effects on the food stamp program as many people lost food stamp stamps (for which they were still eligible) at the same time that they lost TANF benefits.

Federal funding provided to Idaho in 2002 totaled \$62 million (National Center for Children in Poverty, 2005a).

Other food resources in Idaho include the WIC program where mothers may obtain formula for their infants or supplemental food for themselves if breastfeeding their infants. In addition, the network of Community Action Agencies sponsors nutrition programs that distribute donated and USDA commodities to food banks, pantries, and soup kitchens in many communities in Idaho.

#### **4. Health Care Access Security**

Health insurance is a fundamental need in the United States as it facilitates access to affordable preventive, acute and chronic care. It also promotes the use of regular care and therefore decreases reliance on high-cost emergency room and inpatient care. Families recognize the importance of health insurance as reflected in the following quote from an Idaho parent participating in a focus group conducted for the assessment.

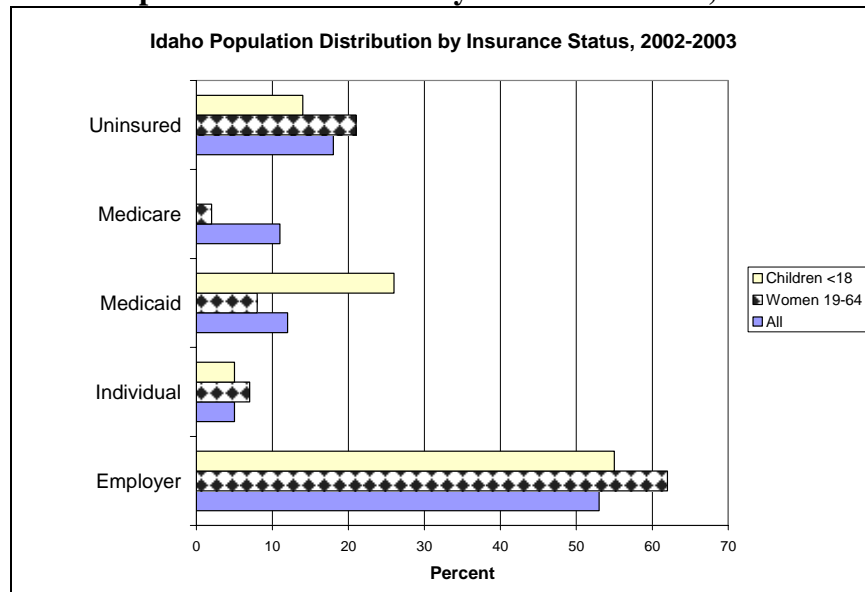
### What Do Parents Say?

*“You know your kid’s sick but if you don’t have health coverage, you are sunk.”*

*Focus Group Participant*

About 85 percent of Idahoans have some form of insurance. This figure includes both children and adults. However, a closer review of the data reveals that a larger proportion of women are uninsured, and almost a quarter of children are enrolled in Medicaid (Figure III-17).

**Figure III-17: Idaho Population Distribution by Insurance Status, 2002-2003**



Source: Kaiser Family Foundation, 2004 (Note: analysis of Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2003 and 2004 Current Population Surveys)

There are also vast differences in coverage by ethnicity. While only 31 percent of Hispanics are insured by their employer, 64 percent of Whites are employer insured. Low-income individuals are more likely to be uninsured or on Medicaid than those 200 percent above the Federal poverty level. Nearly half of all Hispanics in Idaho lack health insurance.

**Table III-14.**  
**Type of Health Insurance by Income and Ethnicity (2002-2003)**

	Low Income (<200% of FPL)	200% or More	Hispanic	White
Employer	20	80	31	64
Medicaid	28	5	21	12
Uninsured	35	12	45	17

Source: Kaiser Family Foundation, 2004 (Note: analysis of Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2003 and 2004 Current Population Surveys)

Of Idaho's uninsured between ages 18 and 64, 80 percent are members of working families. Focus group participants described employers' coverage that only insured the working adult, or a portion of his or her family. The rest of the family was uninsured (Idaho State Planning Grant, 2001).

The prevalence of uninsured varies by county with a high of over 30 percent of individuals uninsured in Owyhee, Fremont, Jerome, and Bear Lake Counties. The greatest concentration of the uninsured resides in the urban centers of Ada, Kootenai, and Canyon Counties (Idaho State Planning Grant, 2001).

Those ages 18-24 are more likely to be uninsured than those in other age categories. There are an estimated 30,000 uninsured children (under the age of 18) that qualify for the Children's Health Insurance Program (CHIP) or Medicaid that are not enrolled (Idaho State Planning Grant, 2001).

### Adequacy of Health Insurance

The financial impact on families of obtaining or not having health insurance was described by focus group participants.

#### *What Do Parents Say?*

*"The only way we can afford health insurance is to have bare bones, catastrophic illness only. Our deductible is \$7,500, so we pay bills up front and that is the only way we can afford health insurance. It's nerve rattling."*

*"You can't afford not to have health insurance, because one major illness could bankrupt your family. We have scrapped the bottom of the barrel, but we've never given up Health insurance."*

*Focus Group Participants*

While it is important to know the number of those uninsured, it is also important to examine the adequacy of health insurance. High deductibles and high copays can affect a family's economic security. In the recent study published in *Health Affairs*, almost half of all personal bankruptcy filers in the United States cited medical causes. Among those whose illnesses led to bankruptcy, 75.7 percent had insurance at the onset of illness. Even middle-class insured families can be financially devastated from trying to pay for catastrophic care (Himmelstein et al., 2005).

Living in a rural State such as Idaho increases the risk of being under- or uninsured. Rural economies tend to be dominated by smaller employers, low-wage employers and the self-employed. When rural residents enter the private insurance market, they are likely to pay higher administrative fees, find fewer health insurance choices, and be underinsured. Rural residents pay a higher proportion of their income for health insurance, because premium rates in the rural United States are comparable to or even higher than those living in urban areas, but average

income is lower. There is also growing evidence that rural residents have health coverage that pays less of their health care bills and that they spend more of their income on health care costs—two of the current definitions of underinsurance (National Rural Health Association, 2004).

Focus group participants described lack of adequate insurance as affecting their health-seeking behavior and family life. For example, it contributed to their choosing a direct-entry midwife, forgoing medical visits, and taking a second job to pay for health costs.

*What Do Parents Say?*

*“Deciding when to take the children to the doctor has been an issue between my husband and I because I’m thinking, ‘Boy, they better get to the doctor. They need it,’ and my husband is worried about the cost, so he’s thinking, ‘You better wait.’ It’s a very valid concern for people that have high deductibles, because it is coming out of our pocket. It’s just a difficult issue for middle income families. I think a lot about this because of my work in early childhood, I know the relationship between my children’s health and how well they are learning.”*

*Focus Group Participant*

From the Family Health Survey, 453 out of 679 respondents (67 percent) stated that health costs were a burden for their family. The most-often-cited reasons for the burden were “out of pocket expenses” (76 percent) and high deductibles (46 percent). Individual health coverage deductibles typically range from \$2,000 to \$5,000 in Idaho. A family of 3 will pay approximately \$350 per month, for a \$2,000 deductible, \$30 copay visits, and a co-insurance of 20 percent, meaning the enrollee pays for 20 percent of all allowed charges.

Being under- or uninsured in Idaho has specific consequences for the MCH population and these are described more fully in the population-specific sections of this report.

## Summary

Critical to an assessment of the needs of Idaho’s MCH population groups and to the subsequent policy and program discussions to address those needs is an understanding of the importance of family security on the health and well-being of pregnant women, infants, children, adolescents, children with special health care needs, and the families who care for them. While many families in Idaho are secure in their ability to provide and care for their members, other families are struggling with economic, housing, food, and health care access security issues. It is important to consider the findings and recommendations of this assessment within the context of family security.

The next section of the report contains a description of the health care infrastructure in Idaho.



# Chapter IV

## Idaho Health Care Infrastructure

---

### Overview

The MCH population groups obtain information, health care, and other health-related services through a variety of organizational entities. Some, other institutions, such as university training programs, exist to support the system of care. Taken together, all these components make up the health infrastructure. In order to understand the needs of the Idaho MCH population and opportunities available to meet those needs, it is important to understand the system that is currently in place. The following is a description of the major components of the infrastructure of the Idaho system of care for the MCH populations.

### A. Public Sector Health and Wellness System

The public sector health and wellness system includes State and local agencies who address health and health-related issues in Idaho. This section provides an overview of the key agencies and divisions involved.

#### 1. *Department of Health and Welfare*

The overall mission of the IDHW is to actively promote and protect the economic, behavioral, and physical health and safety of all Idahoans. The goals of the department focus on area where the IDHW and its partners can:

- Improve health
- Strengthen individuals, families, and communities
- Integrate health and human services.

To accomplish these goals, the IDHW will assure that all employees are knowledgeable, skilled, and accountable in the Department's core competencies. An additional focus is the alignment of structures, people, and technology to meet the needs of the people of Idaho (Idaho Department of Health and Welfare, 2004a).

The Department of Health and Welfare is organized into seven divisions. Three of these divisions—the Division of Management Services, Division of Information and Technology

Services, and the Division of Human Resources—are mainly responsible for administrative functions. The other divisions are described below.

**a. Division of Health**

The Division of Health is organized into five bureaus:

- The Bureau of Clinical and Preventive Services (BOCAPS) is the designated Title V agency and has responsibility for services to CSHCN, health program support, immunizations, reproductive health, STD/AIDS, WIC Nutrition, Women’s Health Check, and Worker Health and Safety. The vast majority of these services are delivered through contracts with the District Health Departments.
- The Bureau of Community and Environmental Health has responsibility over adolescent pregnancy prevention, chronic diseases, environmental health, injury prevention, oral health, and tobacco prevention and control.
- The Bureau of Health Policy and Vital Statistics is responsible for health preparedness, and vital statistics.
- The Bureau of Emergency Medical Services oversees emergency medical services including certification and licensure and communications.
- The Bureau of Laboratories oversees laboratory services.

Unlike the other divisions within the Department of Health and Welfare, the Division of Health does not have regional staff to oversee service delivery. Most of the services are delivered through contracts with the District Health Departments. The District Health Departments are described after the completion of description of the DHW.

**b. Division of Welfare**

The Division of Welfare administers what are referred to as the Self-Reliance Programs in Idaho. The responsibilities of the division include administering TANF, which is named the TAFI Program in Idaho; the Idaho Child Care Program, which subsidizes child care costs for low-income families; Aid to the Aged, Blind, and Disabled; Food Stamps; Refugee Assistance; the Community Service Block Grant; Low-Income Energy and Weatherization Assistance; Emergency Food Assistance; Telephone Assistance, which provides cash assistance to help cover telephone installation and monthly charges; and the Child Support Program. The Division also is responsible for determining Medicaid eligibility. In-person interviews are not required for medical assistance or the child care program but are required for TAFI and Food Stamps. Regional Medicaid Services offices are responsible for administering applications and orientations for new Medicaid providers.

### c. Office of Medicaid

The Office of Medicaid designs, implements and reviews State-funded medical assistance services. Medicaid is a shared Federal and State program. The Federal matching rate for Medicaid in Idaho has been declining with a 73.91 percent match reported for FY 2004, 70.62 percent for FY 2005 and 69.91 percent for FY 2006 (Kaiser Family Foundation, 2005a).

Spending per child enrolled in the program in FY 2002 was reported at \$953 and at \$12,845 for each elderly enrollee. In comparison, the spending per child enrollee for FY 2002 was \$1,227 for the U.S. overall and \$10,026 for elderly enrollees. In Idaho in FY 2002, children comprised 61 percent of Medicaid enrollees, compared to 49 percent nationally. In 2003, 74.7 percent of Idaho Medicaid enrollees were enrolled in managed care (Kaiser Family Foundation, 2005b).

The office is responsible for Medicaid policy and overseeing Medicaid providers. These responsibilities include administering reimbursement to providers, provider licensure and survey, and Medicaid utilization review and fraud control. The Medicaid program has the largest appropriation in the Department of Health and Welfare with an initial appropriation of \$1.05 billion in FY 2005. Over 96 percent of these funds are payments for providers, and 66.5 percent are Federal funds.

One of the key enabling services provided under Medicaid is case management services. These services are available for many of the populations that are covered under this needs assessment including CSHCN. Private contractors provide case management services. These contractors recruit and obtain consent from Medicaid participants. There are four types of case management services provided under Medicaid:

- ***EPSDT case management.*** Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) case management services are provided to those under age 21 who have been identified on an EPSDT case management screen as needing case management services. The case manager's responsibilities are to help the child and family secure and coordinate needed health, educational, early intervention, advocacy, and social services identified in an authorized service plan.
- ***Mental health case management.*** Mental health case management services are provided to adults with a severe and persistent mental illness and functional limitations, and a history of using high-cost medical services. The purpose of these services is to assist eligible individuals to gain access to needed medical, social, educational, mental health, and other services.
- ***Developmental disability service coordination.*** These case management services are provided to adults with developmental disabilities who have a need for service coordination and a desire to live, learn, or work in community-based settings.

- ***Personal care services case management.*** This service is provided to Medicaid participants who have a demonstrated need for personal care services and need assistance to obtain other Medicaid and non-Medicaid services.

The Developmental Disabilities Program within the Division of Family and Community Services oversees the service by certifying the providers who meet the qualifications for providing the service and conducting quality assurance activities.

#### **d. Division of Family and Community Services**

The Division of Family and Community Services includes the Children and Family Services Program (CFS) covering a wide range of children's services, services for persons with developmental disabilities including early intervention services, and the Mental Health and Substance Abuse Program.

##### **i) *Children and Family Services Program.***

The Children and Family Services Program is responsible for administering child protective services, foster care, adoptions, substance abuse treatment and prevention, licensure of children's care facilities, and children's mental health. Currently, each region has a Children and Family Services Program Manager. The program manager reports to a Deputy Division Administrator over program operations. Each region has two chiefs of social work, or an equivalent position, with one chief specializing in child protection and the other specializing in children's mental health. The primary role of the chiefs is to assure that practice is consistent with the goals and values of Children and Family Services. These chiefs have different job duties in each region, but they all report to the regional program manager.

***Child Protective Services, Foster Care, and Adoptions.*** Child protective services are provided through the regional offices. There are seven regional offices and 21 field offices. Each office has a different phone number for reporting abuse and neglect, but people who need to report a case are sometimes told to contact the Idaho CareLine which connects them to the appropriate office. A risk assessment is required for all referrals of child abuse or neglect that fall within the definitions in State law. CFS social workers carry out the risk assessment and, if the child is removed from the home, are responsible for managing the case and referring the child and family to appropriate services. Family preservation, family support, family reunification, and adoption recruitment and support services are contracted out.

***Children's Mental Health.*** A child can be referred for mental health services by a parent, local school district, county probationary officer, juvenile court, or Department of Juvenile Corrections. All mental health services are voluntary and require parental consent unless the child is a threat to himself or herself or others. A child can be treated on an emergency basis if the child exhibits psychotic symptoms, risk of harm to self, or risk of harm to others. Ongoing services require that the child is assessed as having a serious emotional disturbance based on a diagnosis from the Diagnostic Statistical Manual of Mental Disorders (DSM-IV) and a functional impairment based on their score on the Child and Adolescent Functional Assessment Scale (CAFAS). The Department provides a wide range of services including assessment, case management services, day treatment, family support, residential treatment, and crisis

stabilization and response. Children may also receive Medicaid-funded mental health services under the Psychosocial Rehabilitative Services Program (PSR). These services include assessment, crisis support, psychiatric services, and planning activities. PSR services were developed for Medicaid recipients but are available with a parental copayment to children who are eligible for Department of Health and Welfare Children's Mental Health Services, but not eligible for Medicaid. CFS clinical staff or PSR contractors conduct assessments. CFS staff develop a service plan and services are provided by the agency, other agencies, or private providers. In 2002, there were a total of 75 CFS regional staff providing children's mental health services. The total ranged from 8 in Region 5 to 12 in Region 7.

While CFS continues to provide the bulk of mental health services, the State is in the process of developing a community-based system of care. The intent is that children who are accessing services from multiple agencies will begin to have their care managed through local children's mental health councils. This system is described below under the Idaho Council on Children's Mental Health.

## *ii) Developmental Disabilities Program*

The Developmental Disabilities Program provides services to both children and adults with developmental disabilities. There are separate program managers for children and adult services. The responsibilities include overseeing early intervention services through the Infant-Toddler Program; overseeing EPSDT service coordination; and certifying, licensing, and providing oversight to the agencies that provide developmental disabilities services. Adult developmental disability services are provided by private agencies. The Developmental Disabilities Service Coordinator works with the person with the disabilities to develop a case management plan, to arrange the services necessary to implement the plan, to monitor the plan and services, and to revise the plan as needed.

The Infant and Toddler Early Intervention Program is Idaho's Part C Program. This program has the responsibility of providing services to children from ages 0 to 3 with developmental disabilities. Program staff responsibilities include overseeing the services provided and monitoring the program's progress on achieving its goals. In addition, local division staff provides interim service coordination. Interim service coordination is provided until a family selects a contracted care coordinator; the services provided on an interim basis include:

- Educating the family about the Infant-Toddler Program
- Explaining the evaluation process
- Explaining the family's role as a participant on the multidisciplinary team
- Explaining and reviewing the procedural safeguards
- Providing support and resource information on service options
- Facilitating the initial Individual Family Service Plan (IFSP)
- Assisting the family with selection of ongoing service coordinator.

### **iii)     *Adult Mental Health and Substance Abuse Programs***

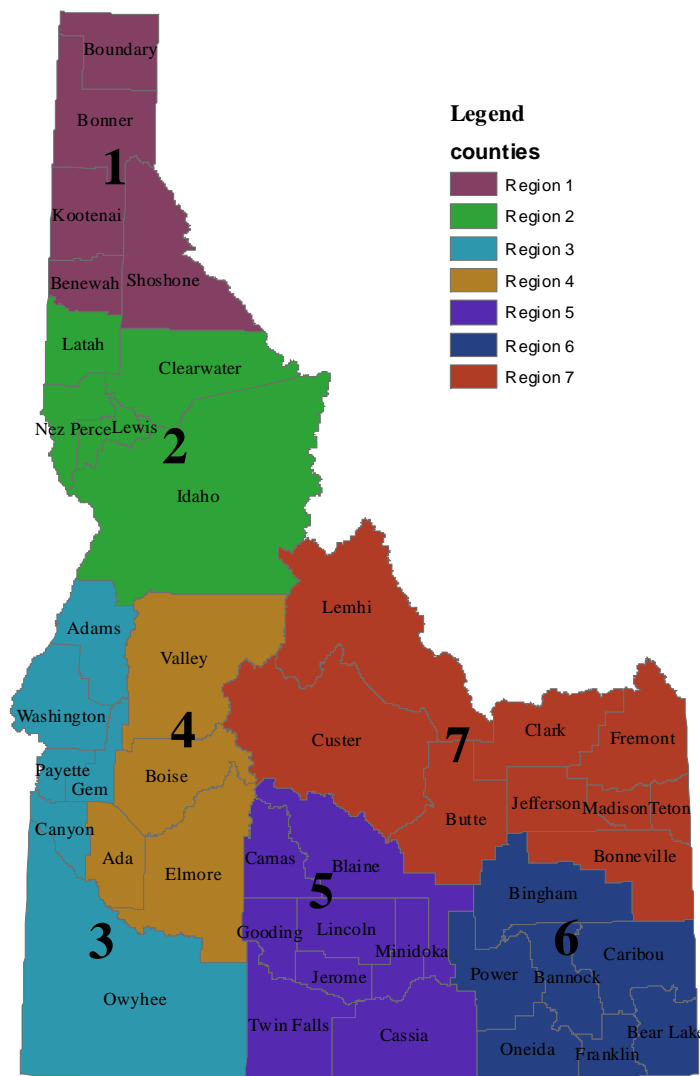
**Adult Mental Health.** Publicly funded mental health services for adults are provided primarily through a network of seven State-operated regional community mental health centers (CMHCs) and two State hospitals. The Family and Community Division Adult Mental Health Program supports systems improvement, oversees Federal grant applications, contract development, and monitoring of contractors. The seven CMHCs have the primary responsibility for the development of a community-based, consumer-guided system of care. Each CMHC has a Regional Mental Health Advisory Board consisting of interested citizens, consumers, and advocates. The Boards provide input and recommendations for changes in the mental health delivery system.

The CMHCs are the designated Regional Mental Health Authorities and have responsibility for the prior authorization of psychosocial rehabilitation services. Prior to FY 2003 the CMHCs also had primary responsibility for assessment and service planning. In response to budget constraints, private-sector case managers have been given responsibility for assessment and service planning.

**Substance Abuse.** IDHW provides funds to treatment providers and prevention programs throughout the State. Services are provided on a sliding-fee basis. There are seven Regional Substance Abuse Authorities which partner with IDHW to establish priority populations and priority prevention needs, ensure that treatment services are available, and work with providers on quality improvement. There is a single statewide contractor for administering prevention services. Local providers of prevention services apply for funding through the State contractor. Treatment services are provided by a diverse array of community-based providers. Business Psychology Associates, a behavioral health managed care company, authorizes care and oversees the provider network.

#### **e.     Regional Health and Welfare Offices**

The Regional Health and Welfare offices are responsible for local administration of the programs that are the responsibility of the Divisions of Welfare, Family, and Community Services and Medicaid. While there is a Regional Director, program staff report directly to the respective division offices in Boise. Up until about 3 years ago, the Regional Director was responsible for managing the local programs and making decisions about local resource allocation. Under this system, there were concerns that programs were not being administered consistently across the State. Program staff in the local offices now report directly to program staff in the State offices. Regional directors have taken on a new role of serving as the agency's liaison in the community. They also are serving as Health and Welfare's representative on the Regional Substance Abuse Authority. However, decisions about allocations of resources within and across regions are made at the State program level. The new role for the Regional Directors has created opportunities by allowing a staff person to dedicate their time to representing the agency within the community and to explore ways resources can be coordinated.



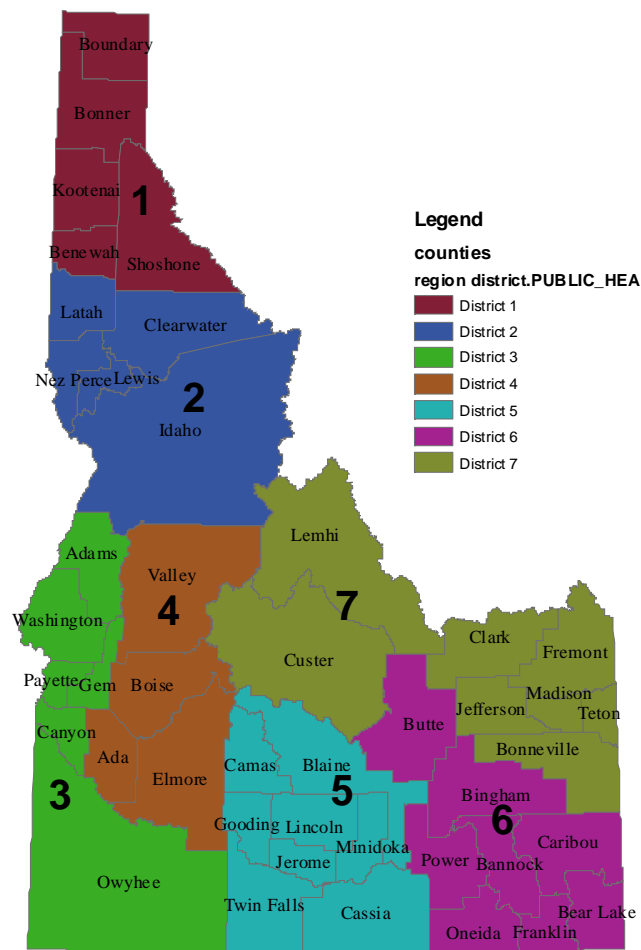
**Figure IV-1: Map of Idaho's Regional Health Districts**

## 2. *District Health Offices*

The Public Health Districts were created by the Idaho Legislature in 1970 to ensure that essential public health services were available to protect the health of all citizens of the State. The Districts are autonomous: State agencies do not have direct authority over their activities. Each of the seven Districts is governed by a Board of Health composed of seven to eight members appointed by the county commissioners from that district. Each Board of Health defines the public health services to be offered in its district based on the particular needs of the local populations serviced. They also employ a director to oversee the daily operations of the districts. Each of the Districts may have several satellite offices within their region. The boundaries of the Public Health Districts are identical to the Health and Welfare Regional boundaries, with one exception: Butte County is in Health District VI and Health and Welfare Region VII.

Table IV-1. Idaho Public Health Districts						
District I Population: 188,838 Sq. Miles 7,654	District II Population: 100,348 Sq. Miles 13,447	District III Population: 213,465 Sq. Miles 12,009	District IV Population: 369,002 Sq. Miles 9,677	District V Population: 167,444 Sq. Miles 11,461	District VI Population: 158,266 Sq. Miles 11,443	District VII Population: 145,865 Sq. Miles 16,986
Benewah	Clearwater	Adams	Ada	Blaine	Bannock	Bonneville
Bonner	Idaho	Canyon	Boise	Camas	Bear Lake	Clark
Boundary	Latah	Gem	Elmore	Cassia	Bingham	Custer
Kootenai	Lewis	Owyhee	Valley	Gooding	Butte	Fremont
Shoshone	Nez Perce	Payette		Jerome	Caribou	Jefferson
		Washington		Lincoln	Franklin	Lemhi
				Minidoka	Oneida	Madison
				Twin Falls	Power	Teton

Source: U.S. Census Bureau, 2004a



**Figure IV-2: Map of Idaho's Public Health Districts**



Although services vary depending on local need, all seven districts provide the essential services that assure healthy communities. These may include:

- Monitoring health status by developing reports that call attention to emerging health problems
- Investigating health hazards
- Empowering people to make good health choices
- Linking people to needed health services or providing them directly if access is limited
- Enforcing laws to protect health.

The Public Health Districts receive income from three sources. About 36 percent of income is derived from the counties, the State General Assembly, and State Millennium Fund. The Millennium Fund is the account holding the State's share of the national tobacco settlement. An additional 25 percent is obtained through fees and another 39 percent from service contracts. The Districts have developed a 2005 Strategic Plan that identifies goals based on the national Healthy People 2010 Goals. The goals focus on physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, immunizations, access to health care, and public health infrastructure (Idaho Public Health Districts, 2004). Each of the Districts prepares a report detailing their priorities and activities.

The Department of Health and Welfare, Division of Health develops contracts with the local District Offices to carry out a number of activities. These include:

- Operating the WIC program
- Providing family planning services
- Providing immunizations
- Providing preventative oral health services
- Investigating and controlling of infectious diseases.

Until recently, the District Offices were also responsible for organizing and administering clinics for the CSHP Program and providing case management services to CSHP participants.

District Health Offices also contract with the Division of Family and Community Services to provide "child find" services for the Infant-Toddler Program. In this role, they provide developmental monitoring, conduct screening and assessments, and initial referrals to services. The Department of Health and Welfare, Division of Welfare contracts with the District Health Office to monitor health and safety standards in child care facilities.

In addition, districts have other responsibilities they carry out, including responsibility for public health preparedness and environmental health, which entails food establishment inspections and sewer and septic monitoring.

### **3. *Idaho's Council on Children's Mental Health***

Idaho is in the process of developing a system of care for children's mental health services. The implementation of the system is taking place in response to the "Jeff D. Lawsuit." The lawsuit was filed over 25 years ago to protect children with SED who were placed in State hospitals. The lawsuit was expanded to include the State's lack of community-based services.

As a result of a 1999 needs assessment of children with SED conducted in response to the lawsuit, the State is in the process of implementing 50 recommendations to create a system of care. The intent of the new system is to deliver integrated, community-based services that cut across agency lines. Children's mental health services are overseen by the Idaho Council on Children's Mental Health consisting of representatives from the Governor's office and the Departments of Health and Welfare, Juvenile Corrections, and Education as well as parent advocacy groups; a county commissioner; and representatives of the legislature, judicial branch, children's mental health service providers, and regional councils. There is a regional council in each of the seven regions. The regional councils are responsible for supporting data collection, recommending the release of funds to local councils, monitoring the use of funds, providing technical assistance to the local councils, and assessing the need for and approving additional local councils. The regional councils are required, at minimum, to include membership from parent or parent advocacy organizations, county probation, the Department of Health and Welfare, the Department of Juvenile Corrections, local school districts, the Regional Mental Health Advisory Board, and each local council in the region.

The first local councils were created in FY 2002 when a total of seven were established. The next fiscal year, the number of councils reached 31 and has recently risen to 34. Additional local councils can be created if it is determined that a need exists for them. The local councils report to the regional councils and are responsible for the staffing of individual cases of children brought to the local council; service coordination and collaboration; initial data collection; representation of the local perspective on the regional councils; the request of funds from the regional councils; and the monitoring of utilization of those funds. In 2002, local councils worked directly with 94 children and their families. In 2003, 110 children were served. Currently, the local councils are serving only a small proportion of the total number of children receiving publicly funded mental health services.

### **4. *Department of Education***

There are 112 school districts and 681 schools in Idaho. Idaho ranked 48<sup>th</sup> among the States and the District of Columbia in per pupil education spending in 2001-2002. Only Utah, Mississippi, and Arizona spent less per pupil. Expenditure per pupil was \$5,923 compared to a figure of \$7,701 for the country as a whole. Idaho schools receive a larger share of their funding from the State than is typical. Idaho ranks 11<sup>th</sup> among States in the percent of revenue coming from State-funding sources (U.S. Census Bureau, 2002).

<b>Table IV-2. Education Expenditures and Revenues in Idaho and the U.S., 2001-2002 School Year</b>		
	<b>Idaho</b>	<b>U.S.</b>
Total per Pupil Spending	\$5,923	\$7,701
<b>Sources of Revenue for Local School Districts</b>		
Local	30.6%	42.8%
State	60.9%	49.4%
Federal	8.6%	7.8%

The Idaho State Department of Education is organized into an administrative section and six bureaus: Finance and Transportation, Special Education, Technology Services, Federal Programs, Curriculum and Accountability, and Certification and Professional Standards. The two main ways that the school system contributes to the health infrastructure are through special education services and by providing health education. The Bureau of Special Education is responsible for overseeing preschool and district special education programs. The school districts are one of the key providers of services to CSHCN. In the past few years, the Bureau has worked with the Division of Medicaid to assist school districts in becoming authorized Medicaid providers. This enables the districts to receive Medicaid reimbursements for children who need special education services and are Medicaid recipients. The Bureau is also working with the Districts to encourage them to bill Medicaid when it is appropriate.

The Idaho Department of Education develops achievement standards and a list of approved curricular materials. School districts may request a waiver if they wish to use other material. For Health Education, the Department has developed five Achievement Standards for Health Education. The standards are that, through health education, students will:

- Acquire the skills to lead a healthy life
- Demonstrate the ability to practice health-enhancing behaviors that reduce health risks
- Demonstrate the ability to use communication skills to enhance health
- Organize, analyze, and apply health information practices and services appropriate for individual needs
- Understand and demonstrate the key components to positive mental and emotional health.

The decision as to whether any program in family life and sex education is to be introduced in the schools is a matter for determination at the local district level by the local school board. The legislature has adopted principles for sex education programs that stress abstinence and view sex education in the schools as a supplement to what is taught at home and church.

## **B. Access to Health Information**

The Idaho CareLine is the central telephone information line that allows everyone in Idaho access to information about health and human services. The CareLine began as a collaboration between the Part C Early Intervention Program and the State Title V agency. The CareLine served as the Part C Central Directory and the Maternal and Child Help Line that is required as a condition of receiving MCH Block Grant funds. The CareLine has evolved over the years to become a much more expansive health and human services resource directory and information and referral service. In May 2002, the Idaho CareLine entered into a collaborative partnership with the 2-1-1 Idaho Project which allows anyone in the State to reach the CareLine by dialing 2-1-1. The effort to relaunch the information line as the “2-1-1 Idaho CareLine” took more than 5 years. The effort involved the support and collaboration of various public and private entities, including the Junior League of Boise, United Way of Treasure Valley, the Mountain States Group, Saint Alphonsus Regional Medical Center, the Idaho Department of Health and Welfare, and the Governor’s Coordinating Council for Families and Children. In November 2001, a 2-year startup grant from M.J. Murdock Charitable Trust was awarded which provided critical funds needed for the project to move forward.

The CareLine is free, statewide, and bilingual. Calls are confidential and a caller does not need to provide his or her name, address, or telephone number to receive services. The hours of operation are 8 a.m. to 6 p.m. Monday through Friday. After-hours calls are answered by voice mail with messages returned the following business day. The CareLine uses an extensive database of health and human service providers to support the information and referral activities. Callers are connected to a wide array of services including prenatal care, immunizations, Medicaid resources, adoption and foster care, child care, emergency food and housing and many other community services.

To include new resources in the database and to keep information current, the CareLine disseminates a service inventory questionnaire to be completed by participating agencies. The CareLine serves all of Idaho, and an Idaho CareLine Customer Service specialist will personally transfer the caller directly to the requested resource in his or her community.

Since converting to the 2-1-1 number, the CareLine has seen an extensive increase in volume. The 83,726 calls in FY 2004 represented a 135 percent increase from FY 2003. There have been 58,862 calls in the first 6 months of FY 2005. This means that for the second year in a row the CareLine is on track for a very large increase in call volume. If calls continue at this pace, the number will top 100,000 for the first time ever.

Participants in the Idaho Family Survey were asked about the CareLine. More than half (55 percent) had heard of the CareLine and 39 percent reporting using the CareLine. Among those who used the CareLine, most had positive impressions. At least 40 percent strongly agreed that the CareLine was helpful, provided resources in their area, and offered help that addressed the problem they called about. A little over 10 percent had problems in all those areas. Clearly, there is still room for improvement, since at least one in five respondents did not report a clearly positive experience with the line. In addition, a few respondents reported that they were unable to reach the CareLine by dialing 2-1-1. It is possible that they had tried using cell phones that do

not incorporate the 2-1-1 feature, but what is clear is that this problem caused them great frustration.

<b>Table IV-3. Experiences Using the Idaho CareLine</b>				
	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Neither Agree nor Disagree</b>	<b>Strongly or Somewhat Disagree</b>
The CareLine has been helpful	45.4	30.8	11.5	12.3
The CareLine provided resources that were accessible to someone living in my area of Idaho	46.0	32.3	10.5	11.3
The help that was offered addressed the problem about which I called	40.0	27.2	18.4	14.4

Source: Idaho Family Survey

Focus group participants and key informants both indicated that the CareLine is better publicized and provides more extensive information about services in Boise and surrounding Treasure Valley area than in the rest of the State, especially the Northern Panhandle. Data from the Idaho CareLine provided some support for this finding. Region IV, which includes Boise, has a considerably higher percentage of calls than the region's share of the population. Region III, which is adjacent to Boise and shares common television and radio stations, is the only other region with a higher percentage of calls than its share of the population. CareLine utilization in Region I, the northernmost region of the State, actually came close to its share of the population in FY 2003 but showed a decline compared to other Regions in FY 2004. Regions III and VI showed the greatest percentage increase in calls between FY 2002 and FY 2003, though all Regions had a substantial increase in call volume. Overall, the CareLine appears to be making progress toward its goal of being a statewide health and social service information resource.

<b>Table IV-4. Calls to the 2-1-1 Idaho CareLine by Region</b>					
<b>Region</b>	<b>Region's Share of State Population July 2003</b>	<b>FY 2003 (July 2002-June 2003)</b>		<b>FY 2004 (July 2003-June 2004)</b>	
		<b>Number</b>	<b>Percent</b>	<b>Number</b>	<b>Percent</b>
Region I	13.8%	4675	13.1%	8781	10.5%
Region II	7.3%	1963	5.5%	3662	4.4%
Region III	15.6%	6064	17.0%	17179	20.6%
Region IV	27.0%	12918	36.2%	29987	35.9%
Region V	12.3%	3009	8.4%	7242	8.7%
Region VI	11.6%	2437	6.8%	8146	9.8%
Region VII	12.4%	2953	8.3%	6662	8.0%
Out-of-State	NA	1682	4.7%	2067	2.5%

Source: Idaho CareLine, 2004

An examination of calls that looks at the language of the caller and the types of information they were seeking shows that Spanish speakers are much more likely to inquire about economic assistance or welfare programs. There has been an enormous increase in the number of calls concerning childcare among both English and Spanish-language callers though it is a still much more common topic for English-language callers. The increase in calls concerning child care (29,523) represents 61 percent of the total (48,025) increase in calls from FY 2003 to FY 2004. Calls about CHIP and Medicaid declined as a percent of all calls between FY 2003 and FY 2004, but because of the huge increase in volume the number of calls on the topic actually increased by a few hundred calls.

<b>Table IV-5. Idaho CareLine Calls by Topic and Language of Caller</b>						
<b>Topic</b>	<b>FY 2003 (July 2002-June 2003)</b>			<b>FY 2004 (July 2003-June 2004)</b>		
	<b>English-language Calls: 96.7%; 34,525 Calls</b>	<b>Spanish-language Calls: 3.3%; 1,176 Calls</b>	<b>Total Calls: 35,701</b>	<b>English-language Calls: 97.0%; 81,177 Calls</b>	<b>Spanish-language Calls: 3.0%; 2,549 Calls</b>	<b>Total Calls: 83,726</b>
Childcare	2.5%	1.2%	2.5%	36.9%	17.1%	36.3%
Welfare	18.7%	32.4%	19.1%	17.2%	41.9%	17.9%
CHIP	17.0%	25.6%	17.2%	7.9%	13.9%	8.1%
Medicaid	17.8%	14.2%	17.6%	7.9%	8.2%	8.0%
Medicaid Dentist	8.3%	5.4%	8.2%	6.7%	3.4%	6.6%
Medicaid Doctor	5.1%	3.4%	5.0%	3.6%	2.6%	3.6%
Miscellaneous	5.2%	3.8%	5.2%	3.6%	2.2%	3.5%
Health, Miscellaneous	5.0%	2.3%	4.9%	3.2%	1.8%	3.1%
WIC	3.1%	3.5%	3.1%	2.1%	2.4%	2.1%
Adoption	3.8%	0.2%	3.6%	3.8%	0.2%	3.6%
Other Topics	13.6%	8.0%	13.4%	10.9%	6.6%	10.8%

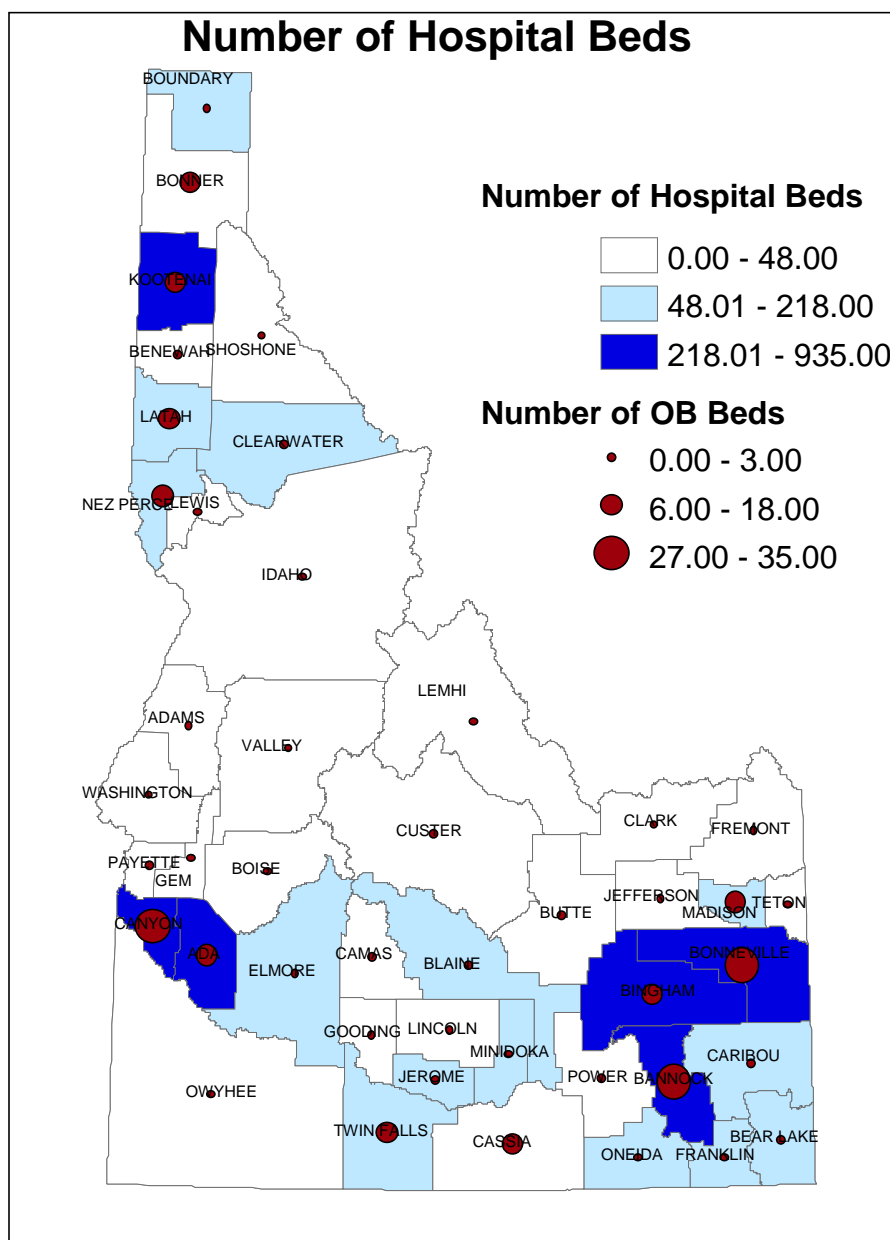
Source: Idaho CareLine, 2005

## C. Other Health and Wellness Providers

### 1. Hospitals

Hospitals are an essential component of the health care delivery system, and the following map displays the hospitals that are 2004 members of the Idaho Hospital Association by number of acute care beds and presence of obstetrical beds.

**Figure IV-2: Idaho Hospital Association Members by Number of Hospital and Number of OB Beds**



Source: American Hospital Association Survey, 2000

Twenty-three of the hospitals are Critical Access Hospitals (CAH). These are rural hospitals that have met certain conditions (e.g., provide 24-hour emergency care services) and are eligible for

cost-based Medicare reimbursement. This program is designed to support the financial viability of small, rural hospitals.

A total of 22 hospitals listed are Disproportionate Share Hospitals (DSHs) (Idaho Hospital Association, 2004). DSHs serve a high percentage of low-income and uninsured individuals. In recognition of the services they provide they are given additional payments for services provided to Medicaid and Medicare recipients. Several out-of-State hospitals also receive DSH funds as they provide services to Idaho residents. The total Idaho DSH payments for FY 2003 totaled \$10,263,964 (Kaiser Family Foundation, 2005c).

The number of all hospitals declined somewhat from 42 in 1999 to 39 in 2002 (Kaiser Family Foundation, 2005d). The number of hospital admissions and emergency room visits per 1,000 people in 2003 was lower in Idaho than for the Nation in 2003.

<b>Table IV-6. Hospital Admissions, Outpatient and Emergency Room Visits, Idaho and U.S., 2003</b>		
	<b>Idaho</b>	<b>U.S.</b>
Hospital Admissions (per 1,000 People)	99	120
Hospital Outpatient Visits (per 1,000 People)	2,026	1,937
Emergency Unit Visits (per 1,000 People)	343	382

Source: Kaiser Family Foundation, 2005e

## **Other Categories of Health Care Provider Organizations**

### **2. Community Health Centers**

Community and migrant health centers (C/MHC) are community-sponsored and -governed not-for-profit practices that provide access to primary and preventive health care designed to be affordable for all Idaho families. There are 7 C/MHC grantees in Idaho with 39 health delivery sites. Collectively these sites provided care to 64,714 patients in 2002 (National Association of Community Health Centers, 2003). The following are the names and locations of the Centers in Idaho along with examples of services provided (Table IV-7).

<b>Table IV-7. Summary: Idaho C/MHC</b>			
<b>Name of Center</b>	<b>Location(s)</b>	<b>Examples of Services</b>	<b>Examples of Special Services</b>
Benewah Medical Center	Plumer, ID	Primary care, all ages Health screenings Laboratory Physical therapy Prenatal Care Pharmacy	Substance abuse counseling Preventive and restorative dental Health and safety education programs Onsite Medicaid enrollment



<b>Table IV-7. Summary: Idaho C/MHC</b>			
<b>Name of Center</b>	<b>Location(s)</b>	<b>Examples of Services</b>	<b>Examples of Special Services</b>
Boundary Regional Community Health Center	Bonner's Ferry, ID	Primary care, all ages Health screenings Laboratory Physical therapy Pharmacy	North Idaho Partner in Care Rural Mobile Clinic Preventive and restorative dental Onsite Medicaid enrollment
Dirne Community Health Center	Coeur d'Alene	Primary care	Onsite Medicaid enrollment
Family Health Services: - Buhl Center - Burley Center - Jerome Center - Behavioral Health Services - Family Health	- Buhl - Burley - Jerome - Twin Falls - Twin Falls	Primary care, all ages Health screenings Obstetrics Laboratory Physical therapy Prenatal care	Onsite Medicaid enrollment Mental health counseling
Glens Ferry Health Center - Valley Center - Desert Sage Center	- Glens Ferry - Grandview - Mountain Home	Primary care, all ages Obstetrics Laboratory	Health and safety educational programs Dental Health Onsite Medicaid enrollment
Health West, Inc. - Aberdeen Clinic - American Falls Clinic - Lava Medical Center - Downey Clinic - Old Town Clinic	- Aberdeen - American Falls - Lava Hot Springs - Downey - Pocatello	Primary care, all ages Obstetrics Health screenings Laboratory Physical therapy Prenatal care	Onsite Medicaid enrollment
Terry Reilly Health Services - Canyon Dental - Teen Clinic - SANE Solutions (3 sites) - Homedale Clinic and Dental - Marsing Clinic - Melba Clinic and Dental - Boise Clinic and Dental - Nampa Clinic - Behavioral Health Center	- Nampa - Homedale - Marsing - Melba - Boise	Primary care Obstetrics Family Planning Urgent care	Behavioral health Onsite Medicaid enrollment

Source: Idaho Primary Care Association, 2005

These Centers are located in 22 medically underserved Idaho communities. The Centers play a major role in providing health services to the MCH population with each Center offering prenatal care and reporting that slightly over 37 percent of the total number of patients are under age 19 years. Each Center also has the ability to provide translation and interpretation services, which is

important in that 37.5 percent of Community Health Center (CHC) patients are Hispanic and may be in need of these services. In 2002, almost 65 percent of CHC patients reported incomes at or below 100 percent of the FPL, with another 18.3 percent with incomes between 101-150 percent FPL and 6.1 percent with incomes between 151 and 200 percent of the FPL. In addition, 10.8 percent of Health Center patients reported incomes over 200 percent of the poverty level. Of the total number of Health Center patients in 2002, 46.6 percent had no health insurance, 22.1 percent had Medicaid or the State Children's Health Insurance Program (SCHIP), and 21.8 percent had private insurance. As a result of increased Federal funding and expanding need, CHCs are growing in importance as a key component of the Idaho health care system (National Association of Community Health Centers, 2003).

Idaho's CHCs received far less of their funding from State and local grants and Medicaid compared to CHCs in other States. This may be an indication that the important and growing role of CHCs has yet to be recognized by the public sector in Idaho. This possibility is supported by findings from key informant interviews that indicated partnerships between CHCs, District Health Departments, and State Health agencies have been limited to date. The relatively high percentage of private insurance and patient self-pay revenue suggests that Idaho CHCs are providing useful services for people who might be able to afford other types of care but find the location or the services offered by their local CHC to be a better choice.

<b>Table IV-8. Distribution of Revenue by Source for Federally Qualified Health Centers</b>		
<b>Revenue Source</b>	<b>Idaho</b>	<b>United States</b>
Federal Grants	37.5%	25.5%
State & Local Grants/ Contracts	1.7%	9.4%
Foundation/Private Grants/Contracts	1.1%	3.2%
Medicaid	23.1%	35.5%
Medicare	4.4%	5.5%
Other Public Insurance	0.5%	2.5%
Private Insurance	10.7%	6.2%
Patient Self-Pay	10.9%	5.9%
Other Revenue	10.0%	6.4%

Source: Kaiser Family Foundation, 2005f

### **3. Rural Health Centers**

Rural Health Clinics were established by the Rural Health Clinic Services Act enacted in 1977 to help meet the primary and emergency health needs of the rural communities. There are over 3,000 RHCs through out the Nation certified by CMS. Rural health services provided by independent RHCs owned and operated by a physician, nurse practitioner, physician's assistant, and/or certified nurse-midwife. In addition, the RHC may be owned and operated by a Medicare participating provider (hospital, skilled nursing facility, and home health agency).

RHCs are paid on the basis of a face-to-face encounter using cost-based reimbursement. To be eligible for participation in the RHC program, a facility must apply for and become certified as a RHC. To qualify, a facility must be located in an area defined as rural and as having a shortage of personal health care services or primary care medical services. Nationally, Medicaid, uninsured, self-pay, and free or reduced-cost care patients account for 45 percent of their overall volume. There were 44 RHCs in Idaho in 2004 (Kaiser Family Foundation, 2005g). They received \$7.0 million in Medicaid funding in FY 2004 (Idaho Legislative Services Office, 2004), up from \$3.1 million in FY 2001 (Idaho Legislative Services Office, 2001).

#### 4. *Tribal Health Services*

Federally recognized American Indian tribes and Alaskan Native corporations enjoy a government-to-government relationship with the United States of America. This unique relationship has been given substance through numerous Supreme Court decisions, treaties, legislative acts, and Executive Orders. The provision of health services grew out of this government-to-government relationship. Congress passed the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) to provide tribes the option of either assuming from the IHS the administration and operation of health services and programs in their communities, or to remain within the IHS administered direct health system.

<b>Table IV-9. Tribal Health Centers in Idaho</b>				
<b>Tribe</b>	<b>Health Center</b>	<b>Location</b>	<b>Services</b>	<b>Active users 2002</b>
Coeur d'Alene	Benewah Medical Center	Plummer	Programs include: Comprehensive primary care, dental, MH, drug and alcohol, youth shelter.	3,611
Kootenai*	Kootenai Tribal Clinic	Bonnors	Primary care, MCH	169
Nez Perce*	Nimiipuu Health Center	Lapwai-Kamiah	Programs include: community and MCH health, WIC, drug and alcohol, child protective IHS services include dental, health education, lab, pharmacy, MH	3,433
NW Band of Shoshoni	Does not operate a health center – use Fort Hall IHS			112
Shoshone Bannock*	Not-So-Gah-Nee Health Clinic	Fort Hall	Programs include: MCH, preventive health, counseling and family services, chemical dependency, dental, and WIC	5,824

\*Supported fully or partially under a PL 93-638 self-governance contract  
Source: Northwest Portland Area Indian Health Board, 2005

## 5. Professional Schools

There are no medical or dental schools in Idaho. There have been some discussions about developing a medical school at Idaho State University, but there are no firm plans to carry this out at this time. There is, however, a College of Pharmacy at Idaho State University that offers a range of programs in pharmacy including a doctor of pharmacy. While there is no nurse-midwife program in the State, the Frontier Midwife Training, although located in Kentucky, has developed a program using State-based preceptors to prepare nurse-midwives. Programs are also available in Seattle, Washington, and Portland, Oregon. At least some of the lay midwives delivering babies in Idaho have received training from these programs. The following table displays the names and locations of nursing programs in Idaho.

<b>Table IV-10. Nursing Programs in Idaho</b>			
<b>School</b>	<b>Location</b>	<b>School</b>	<b>Location</b>
Boise State University	Boise	Lewis-Clark State College	Lewiston
Brigham Young University	Rexburg	North Idaho College – *	Coeur d’Alene
College of Southern Idaho *	Twin Falls	NW Nazarene University	Nampa
Idaho State University	Pocatello	University of Phoenix	Boise and Other Locations Throughout State
* Limited to Associate Degrees and Practical Nursing Program			

Source: All Star Directories, 2005

The Idaho State University – College of Health Professions in Pocatello offers programs leading to the following degrees or specialties:

- Audiology
- Dental Hygienist
- Health Care Administration
- Nutrition/Dietetics
- Physical Therapy
- Physician Assistant
- Radiographer
- Speech-Language Pathology

The University also offers a master of public health program, the only such program in Idaho.

Boise State University – College of Health Sciences, located in Boise, offers the following programs:

- Health Information Technology and Management
- Radiological Technology
- Respiratory Therapy
- Sonography

There are a variety of other public and private programs offering training in health care and health support services.

## **6. Professional Organizations and Associations**

**Idaho Medical Association.** The Idaho Medical Association (IMA) has over 1,800 members. Predominant membership is comprised of nearly 1,600 actively practicing physicians, including residents, with the balance of members comprised of retired physicians, physician assistants, nurse practitioners, and medical students. The IMA's physician members represent 62 medical and surgical specialties. A high percentage of IMA members are board certified by their specialty accreditation organizations. Many IMA members have multiple specialties and board certifications. The IMA is comprised of seven Trustee Districts and 14 component medical societies. Representatives of each component society comprise the IMA House of Delegates, which meets once a year at the IMA Annual Meeting.

**Idaho Primary Care Association.** Idaho Primary Care Association (IPCA) founded in 1983 is a not-for-profit membership organization serving CHCs and similar organizations that provide primary health care to underserved populations in Idaho and bordering communities. IPCA coordinates and facilitates shared activities among CHCs and advocates for the expansion of preventive and primary care among underserved populations. IPCA works with organizations interested in developing new CHCs or expanding CHCs to new sites including helping them with the Federal application process.

**Idaho Chapter of the American Academy of Pediatrics.** The Idaho AAP works with pediatricians and others around the State to address a range of health care issues involving children. These issues have included the creation of a volunteer immunization registry, SCHIP enrollment, asthma, and parent education. The Executive Director of AAP is a nurse at St. Luke's Hospitals and the Coordinator for the Idaho Perinatal Project.

**Idaho Perinatal Project.** While not an association in and of itself, the Perinatal Project is an umbrella organization for a number of key MCH Associations. The Idaho AAP, Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and American College of Obstetrics and Gynecologists hold business meetings during the Perinatal Project Conferences. The conference provides an opportunity for networking among different provider types and offers continuing education credits for a variety of fields.

**Idaho Rural Health Association.** The Idaho Rural Health Association is a project of the Institute of Rural Health at Idaho State University. The purpose of IRHA is "to improve the

health of rural Idahoans and populations through establishing access to appropriate and equitable health care services and to assist its members in providing leadership on rural issues through advocacy, communications, education, evidence-based research, and community health education.” The organization has held four biennial conferences; the last in 2004 included joint sessions with the Idaho Psychological Association.

Other professional organizations include the Idaho Chapter of the American College of Nurse-Midwives, the Academy of Family Physicians, and the Idaho Nurses Association.

## **7.     *Advocacy Groups***

***Idaho Parents Unlimited (IPUL).*** IPUL is a statewide organization founded to provide support, information, and technical assistance to parents of children and youth with disabilities. Since 1989, IPUL has been designated as Idaho’s Parent Training and Information Center (PTI) by the U.S. Department of Education, which provides funding for its programs. IPUL conducts regional workshops to inform families about a variety of topics including special education policies, written material, individual consultations, and a toll-free information number for families.

***Idaho Covering Kids and Families*** is a 5-year initiative funded by the Robert Wood Johnson Foundation that works at the State and Community-level to promote the identification and enrollment of children in health insurance. There are both a statewide coalition and 3 community partnership sites covering 11 counties.

***The Idaho Association for the Education of Young Children (IAEYC)*** is both a professional organization for early childhood educators and an advocacy organization focused on early education issues. IAEYC has been the holder of the Healthy Child Care America grant that promotes stronger links between health and child care and conducts Medicaid and SCHIP outreach in child care settings. IAEYC provide scholarships for child care providers to increase their training and education and advocates for improved child care regulations.

## **D.     The Provider Picture**

### **1.     *Health Professional Shortage Designations for Rural Areas***

The Federal Government has established two main health care shortage area designation systems, Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Medically Underserved Populations (MUAs/MUPs), to help recruit, retain, and support RHPs and the provision of services to rural areas. These shortage area designations are used by multiple Federal agencies to determine eligibility and funding preference. Currently, only 9.6 percent of nonmetropolitan counties have no designation as full- or partial-county HPSAs or MUA/MUPs (Hartley and Gale, 2003).

## **a. HPSA Designations**

Areas designated as HPSAs have inadequate access to one or more of the following categories of care: 1) primary care, 2) mental health care, and 3) dental care. Areas must exceed a specified ratio of population to full-time-equivalent providers and lack adequate access to health services in adjacent areas. Lastly, shortage areas can be designated at the county and subcounty levels. Within each of these levels, shortages can apply to the entire population, a geographic HPSA, or a particular population group, a population HPSA. Population subgroups may include federally recognized tribes, migrant and seasonal workers, and the low-income among others (Hartley and Gale, 2003).

The majority of counties in Idaho have areas with at least one of the three categories of HPSA designations (IDHW Office of Rural Health and Primary Care, 2004). Eighty-four (84) percent of counties had current or pending primary care HPSA designations in 2004. The proportion has not significantly changed since the late 1990s. In addition, about 68 percent of counties have a dental care HPSA designation. This represents a decrease since 1998, when 78 percent of counties in Idaho had dental care HPSA designations (Idaho Department of Health and Welfare, 1999). However, the number of counties with geographic dental HPSAs has increased from 7 in 1998 to 14 in 2004. This may indicate that the health professional shortage has worsened in these counties and now affects the entire population rather than just a subgroup. Lastly, all 44 counties have mental health care HPSA designations. This represents a significant recent increase. In 1998, no counties in health districts 1 and 4 had a mental health care HPSA designation. Moreover, all of these designations are geographic HPSAs and therefore represent mental health professional shortages for the entire population in those areas (Idaho Department of Health and Welfare, 2004b).

## **b. MUA/MUP Designations**

The MUA/MUP system was initially established as a means to identify ideal areas to locate Community and MHCs. Areas designated as MUAs/MUPs are similar to primary health care HPSAs, but have less rigorous requirements. Communities that fail to qualify for a HPSA designation often obtain MUA designation to ensure they will qualify for some Federal funding. Communities applying for MUA designation are assigned a score using the Index of Medical Underservice (IMU). The IMU is based on four variables: 1) ratio of primary care physicians per 1,000 people, 2) IMR in the area or among the population group, 3) percentage of the population living below the FPL, and 4) percentage of population age 65 and older. The lower the score, the more underserved a community is. Areas with an IMU score of 62.0 or lower are designated as MUAs and MUPs (Hartley and Gale, 2003).

Just over half, 53 percent, of Idaho's counties had at least one area with a MUA/MUP designation in 1998 (Idaho Department of Health and Welfare, 1999). This proportion has since grown to 68 percent of counties in 2004 (Idaho Department of Health and Welfare, 2004c). Also, in 1998, there were only two counties with MUP designations, but this number increased to seven in 2004. Most designated counties scored just below the 62.0 IMU cutoff. However, several counties had relatively lower scores and thus a more severe health care shortage. Clark,

Elmore, Owyhee, and Boise Counties all scored less than 51.0 on the IMU in 2004 (Bureau of Primary Health Care, 2005).

### **c. Physician Availability**

As reported in the Statistical Abstract of the United States: 2004-2005, 2,158 non-Federal physicians were in active practice in Idaho in 2002 (U.S. Census Bureau, 2004b). The physician rate per 100,000 residents was reported as 161, the lowest rate of all States and Puerto Rico. A survey conducted by the Dartmouth University, Center for Evaluative Clinical Sciences using 2000 physician supply data and 2000 Census data indicates that 87 general pediatricians, 13 pediatric subspecialists, and 530 family practitioners are practicing in Idaho.

Using data from the American Medical Association, the Kaiser Foundation has developed information detailing the race and ethnicity of non-Federal physicians by State. In 2003, the number of white physicians in Idaho was reported as 1,711 (71.0 percent of the total number), 10 Black physicians, 35 Hispanic physicians (1.45 percent), 37 Asian or Pacific Islander physicians (1.54 percent), and 2 American Indian or Alaskan Native physicians. Data were not available for 598 physicians (25 percent) (Kaiser Family Foundation, 2005h).

## **E. The Financing Picture**

### **1. State and Federal Appropriations**

#### **a. FY 2005 State Appropriations**

Over \$3 billion a year are spent on health care in Idaho (National Health Statistics Group, 2004). Twenty (20) percent of all State dollars are expended for health and social service programs in Idaho, but this category accounts for 32 percent of government spending when Federal funds are included.

Seventy-three (73) percent of all moneys appropriated to the Department of Health and Welfare are expended by the Medicaid Program (Idaho Legislative Services Office, 2004). Since 1995, growth in the Department of Health and Welfare (less Medicaid) has remained relatively flat, while Medicaid has grown significantly. From 1990 through 2005, Medicaid has grown 935 percent, compared to the rest of the Department budget, which increased by 112 percent. Medicaid made up 5 percent of the State General Fund budget in 1990 but has grown to about 14 percent in 2005. The single biggest category of expenditures under Medicaid in FY 2004 was prescription drugs, which accounted for \$146.3 million or 15 percent of all expenditures. Inpatient hospital costs were a close second at \$145.3 million followed by nursing facilities, which mostly serve the elderly, at \$124.8 million (Idaho Legislative Services Office, 2004).

When comparing Medicaid enrollment and expenditures, most Western States rank in the lower half nationally. From 1998 through 2002, expenditures grew significantly, while the cost per enrollee went down in Idaho, Nevada, Utah, and Wyoming (Idaho Legislative Services Office,



2004). This suggests that most of the increased cost was due to increasing enrollment in these States.

Approximately \$38 million dollars were appropriated to public health in FY 1995 and \$68.8 million in FY 2005, reflecting an annual change of 6 percent and a total change of 78.9 percent (Idaho Legislative Services Office, 2004). This includes funding to District Health Departments, but excludes Medicaid expenditures.

During the key informant interviews, one of the major areas of concern involved the planned sunset of the half-cent temporary sales tax increase that the legislature enacted in 2003 because of the economic downturn. This decrease will take place June 30, 2005. The temporary increase is expected to contribute \$178.9 million dollars to the State revenues in FY 2005, which is 8.1 percent of total revenue. There is a great deal of concern among the health and social service community about that loss of revenue, especially at a time when Federal funding for health and social services may also face reductions.

#### ***b. Federal Appropriations***

According to the Consolidated Federal Funds Report for Fiscal Year 2003, the Federal Government per capital expenditure by Idaho was slightly in excess of \$6,000 (U.S. Census Bureau, 2004c). This compares to an U.S. average of \$7,000 and the highest average in Alaska of over \$12,000 and the lowest in Nevada of \$5,200. Total Federal Government expenditures by Idaho in 2003 were \$8.6 million compared to \$5.3 million in 1995.

There are a variety of sources of Federal funding for health and human services that flow into Idaho. The table below lists a few of those sources and the total amount of spending. There are many other programs that provide services to the MCH populations in Idaho. For example, the Department of Housing and Urban Development provided \$77.3 million in funds to Idaho in 2003. A portion of these funds is directed to a segment of the MCH population to address one of their most basic needs: housing. The wide range of Federal funding services and the extensive amount of total spending illustrates the need to consider a wide range of services and funding sources when considering how to address the needs identified in this assessment.

**Table IV-11.  
Federal Funding for Selected Health and Human Service Programs in Idaho  
2003**

<b>Source of Funds</b>	<b>Total Amount FY 2003 (in Millions of Dollars)</b>
Medicaid	\$644.9
Food Stamps	\$76.6
TANF	\$37.5 <sup>1</sup>
Head Start	\$30.2
WIC	\$17.9
Child Care and Development Block Grant (Mandatory and Matching Funds)	\$10.8
Social Services Block Grant	\$7.8
Maternal and Child Health Block Grant	\$2.7
Early Intervention Program	\$2.2
Preschool Special Education	\$2.1
Family Planning Services	\$1.5
Comprehensive Community Mental Health Services for Children and Families	\$1.4

Source: U.S. Census Bureau, 2004c

## F. Data

The Health Districts and the Regional Health and Welfare offices reported limited use of data for program planning. Most of the key informants we spoke with said they had little data available for these purposes. Most of the data they saw on a regular basis were process measures such as how many clients were served. The major exception was the Infant-Toddler Program and the Special Education Program who made extensive use of program data to set priorities and establish program goals. The Part B and Part C annual performance reports required by the Department of Education have some useful features that are worth emulating in other performance reports (Idaho Department of Education, 2004).

States are required to report trends over time on indicators and to account for both progress and slippage. Future activities designed to improve the results on the indicator are also listed. If data are not available, efforts to develop that data are noted. Performance measures that require qualitative assessments are also treated the same with a need to talk about trends and reasons for progress or slippage. These features make the data useful for understanding the current status of the program and for focusing program staff on improving both performance and data. It should be noted that one of the flaws of the reporting system is that States are required to report on an enormous number of indicators, which is burdensome and can detract from the focus on key

---

<sup>1</sup> Idaho's total TANF allocation in FY 2003 was 53.4 million. The State transferred 8.7 million to the Child Care Development Fund Block Grant and 1.4 million to the Social Services Block Grant. An additional \$12.2 million was unspent at the end of the year. These unspent funds were available for carryover (Office of Family Assistance, 2004).

indicators of program performance. Performance improvement efforts that borrow the overall approach without incorporating the flaws could be very useful.

## **G. Title V**

A major component of the health care infrastructure in each State is the Title V Program. As described earlier, every 5 years, States are required under the Title V Maternal and Child Health Grant to conduct a comprehensive MCH assessment. This section describes Title V and the Block Grant and addresses the issue of how Title V is and can be used to meet the needs of the MCH population.

### **What is Title V?**

The Title V Maternal Child Health Block Grant statute is authorized to improve the health of all mothers, infants, children, youth, and CSHCN consistent with national health objectives. Like public health programs, Title V always has focused on entire populations, unrestricted by categorical eligibility requirements. The program's statutory mission remains *to improve the health of all mothers and children*. With roots in child labor protections, child welfare, and health, Title V provides for comprehensive, family-centered policies and programs.

Title V is intended to enable each State to provide and assess quality MCH services, reduce infant mortality, prevent diseases and disabilities, promote health, provide services to children and youth with disabilities, and promote community-based, coordinated care. The program is referred to as “Title V” because the Social Security Act of 1935 included a section (Title V) authorizing grants to States to promote maternal child health. While Title V has evolved over the years to strengthen accountability while maintaining State flexibility, its mission has remained the same: improve the health of mothers, infants, children, youth, and CSHCN in each of the States and Territories.

Each state has a Title V Agency generally housed within the State’s public health agency’s organizational entity focused on maternal, child, and family health issues.

### **How Do States Obtain Title V Funds?**

Each State receives Title V funds earmarked for the improvement of MCH. The amount each State is allocated from the overall Federal allocation is calculated on a formula basis factoring in child poverty rates and the level of funding the State received prior to the development of a Block Grant approach. States are required to match \$3 for every \$4 that is allocated. The match can include local expenditures on MCH. A Block Grant means that States receive a block of dollars that are not tied to specific categorical services. As a block grant, States have extensive flexibility as to how their funds are used as long as activities are focused on the improvement of MCH. However, some guidelines are in place to assure that attention is paid to specific MCH population groups. States must document that 30 percent of their MCH Block Grant funds are used for prevention and primary care activities for children, with another 30 percent directed to activities to service CSHCN and their families.

**The Idaho Title V Agency** is the Department of Health's BOCAPS. The Idaho 2004 Title V Block Grant Award was \$3,387,761. Thirty (30) percent of the block grant was used to support primary and preventive care for children, and 45 percent was used to support programs and initiatives for CSHCN. The State and local matching funds amounted to \$2.54 million, \$1.54 of which consisted of local health district funds invested immunization and reproductive health programs.

Among other things, Idaho used Title V funds to support:

- Activities to improve access to and quality of care for CSHCN
- Comprehensive reproductive health services for low-income residents
- Improvements in access to dental services including dental sealant programs for low-income children
- Access to genetic and metabolic specialists and genetics counseling
- Health surveillance activities in the District Health Offices
- The Idaho Perinatal Risk Assessment Tracking Survey.

Each year the state Title V agency must prepare a Title V application that describes how the MCH funds will be used to meet the identified needs of mothers, infants, children, youth, and CSHCN in their State. This application must be accompanied by an annual report that describes the outcomes from the previous year achieved through the auspices of the Title V program. Every 5 years, each State is required to conduct a comprehensive assessment of the needs of their MCH population groups and of the capacity of systems in the State to address those needs.

### **Title V in other Program Statutes**

To promote collaboration among programs designed to serve the MCH population groups, other programs have statutory requirements to work with the State Title V agencies:

- The **Medicaid** statute was amended in 1967 to require that States provide for agreements with Title V agencies to deliver Medicaid services. This language has been interpreted to place Title V in the position of payer of last resort, after Medicaid. The language also assures that Title V services can be billed to Medicaid for Medicaid-eligible children and offered free of charge to others. This provision, which is contrary to general Medicaid policy requiring payment for all services, has been used in Title V-supported, school-based health programs. Finally, some have used the language to argue that Title V programs should receive cost-based Medicaid reimbursement. Federal Medicaid regulations provide additional requirements for Medicaid agreements with Title V.
- **Amendments to Medicaid** to address managed care made special provisions for CSHCN, citing Title V as one category in defining special needs children exempt from mandatory enrollment.

- The Federal ***State Children's Health Insurance Program*** legislation requires States to coordinate with MCH programs. Although Title V is not specifically cited, this was the intent behind the language.
- In the ***Supplemental Security Income (SSI)*** for Disabled Children Program, reference to Title V has provided the basis for State CSHCN programs to receive lists of all children enrolled in SSI. These lists have facilitated Title V outreach and follow-up to assure these children are linked with needed services. This policy also helped support a Title V role in outreach and recertification efforts following changes in Federal eligibility rules in the 1990s.
- The authorization for the federal ***Healthy Start*** program requires grantees to coordinate their services and activities with state Title V agencies.

As the only Federal program with a focus on all mothers, children, and families, Title V is mandated to work with the entire range of public and private sector organizations, agencies and initiatives that address issues related to improving the health of women, infants, children, youth, and CSHCN. The State Title V agency therefore has a unique perspective on the State's MCH system and can and should focus on understanding the system's overall strengths and challenges so that plans can be developed to address the challenges.

### **Moving from Paying for Services to Building Systems of Care**

MCH and CSHCN programs historically have played a strong role in "filling the gaps" or serving as part of a "safety net" for low-income, underserved, and special needs populations. Many State programs historically filled this role by directly providing services through state and local clinics. As the Nation took action, beginning in the late 1980s, to improve health care coverage for children and pregnant women, and as Medicaid recipients moved to managed care delivery systems, public health programs re-examined their roles. There was less of a role for these systems in providing direct health care. The trend in moving away has continued especially with the advent of the SCHIP and more recently with the expansion in the number of CHCs.

#### ***Building a System for Children with Asthma***

*Traditionally, public health (using epidemiological methods) works to eliminate or reduce environmental contributors affecting asthma rates. Health care providers medically managed children with asthma. Child care centers and schools sought help preventing and managing asthma in efforts to reduce absenteeism. The Title V systems-building role is to bring together all the stakeholders and assure that all of the components and strategies are carried out in a coordinated and integrated way and monitored, evaluated, and adjusted as necessary. The Title V Program leads only some of these components, but it works with the others to ensure that the entire picture is addressed and that the system is linked and responsive to families.*

As a result, in a desire to use Title V funds as effectively as possible, MCH Title V programs are decreasing their role in "direct service" while focusing more on systems building. Systems building means that instead of using all the Title V funds to pay for specific services for a few, the focus is on building and sustaining a *system* of services

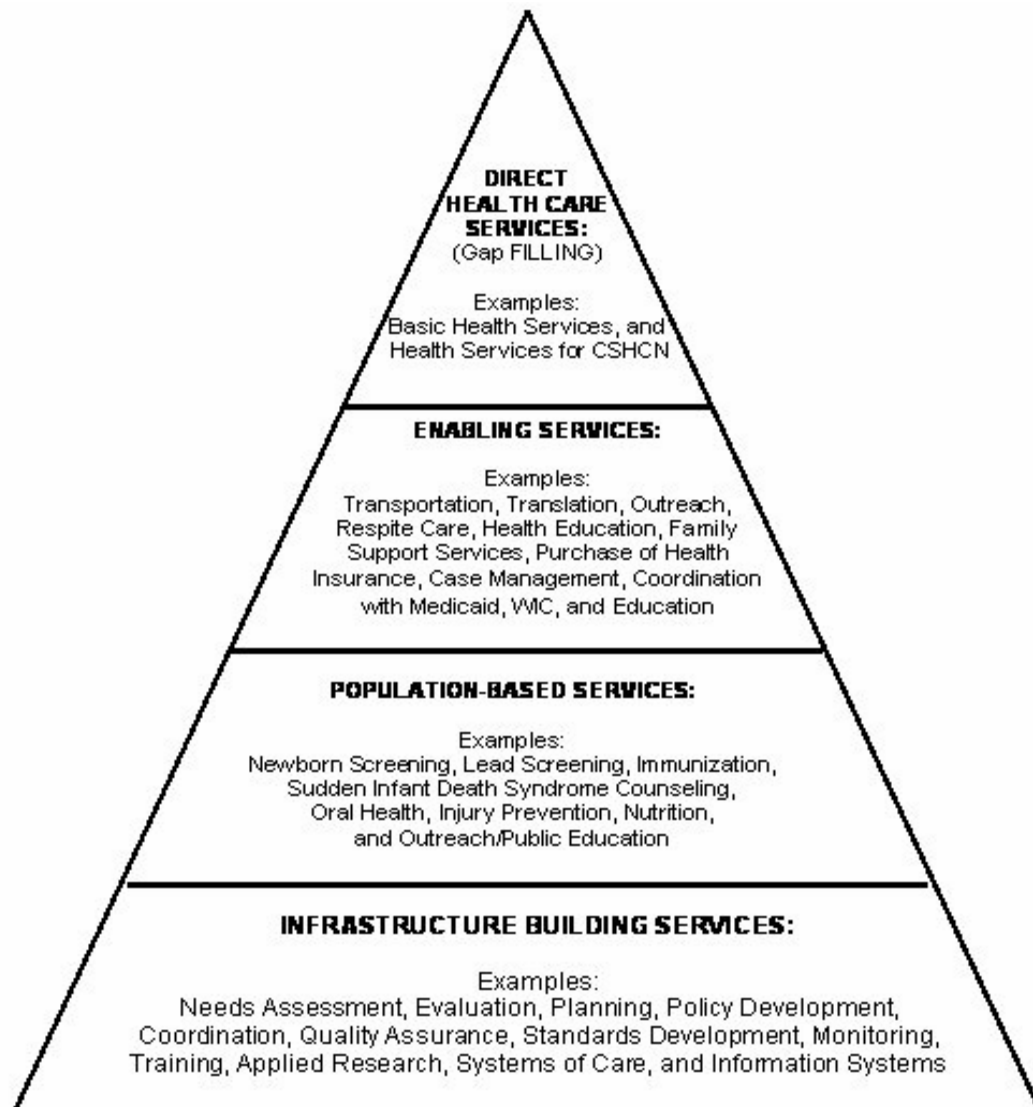
that will care for the many. Title V programs build systems of care by working collaboratively with the public and private health sectors, health care insurers, and the full array of child and family service organizations and agencies. Title V funds are used to conduct assessments and provide leadership to mobilize and convene providers and consumers to plan, implement, monitor, and evaluate strategies to promote systems of care for mothers, children, and families. Title V funds can be blended with other State and Federal resources to provide seamless care to the MCH populations.

Over the last several decades, the Federal Maternal and Children's Health Bureau (MCHB) has placed strong emphasis on systems development. Congress first added language focusing on this Title V role in 1987 and later in the 1989 amendments. State systems development for children and youth with special health care needs is now incorporated into national health objectives as well as Title V performance measures. Title V agencies and their partners strive to develop systems of care that are family centered, comprehensive, coordinated, culturally competent, and community based.

### **The Core MCH Services Pyramid**

In the 1990s, the Federal MCHB developed a framework for Title V that graphically represents the role of the program as the foundation for the family health system and helps to visualize the shift in emphasis from direct services to systems building.

Now known as the MCH pyramid, the framework is consistent with the essential public health services described below and distills core MCH services into four main categories within an overall system of care.



- **Infrastructure Building Services** are services and activities that are important to the entire MCH system.
  - **Example:** Services for data collection and data analysis used for policy and program development and evaluation
- **Population Based Services** in this framework are largely primary prevention programs, universally reaching everyone that might be affected or in need.
  - **Example:** Services for the organization, promotion, provision and monitoring of immunizations for all children in the State
- **Enabling Services** help families access and use health services and are usually targeted to families that have special needs or face specific barriers.

- **Example:** Services that provide families with information about available resources and assistance in using them
- **Direct Health Care Services** are directly provided to individuals by grantees, contractors, or State or local agency staff. Title V programs commonly support prenatal care, well-child and school-based health services, and specialty services for children and youth with special health care needs.
  - **Example:** Prenatal care, well-child care, or specialty services for a particular MCH population groups

Federal Title V requirements, including applications, annual reports, and performance measures, are tied to this framework.

Title V's role has always been to "assure" services, a role for public health also emphasized in the Institute of Medicine's core public health roles. State leaders can assure services through multiple mechanisms, including needs assessment, planning, and recommendations to State policymakers and other agencies to fill gaps. But when no other recourse is available, State leaders use Title V resources to provide access. As the need for Title V to fund direct services has diminished, States have begun to shift resources down through the pyramid to support enabling, population-based, and infrastructure-building services.

Because of the flexibility inherent in Title V, it is a resource that States can use to diminish the fragmentation and duplication that so often accompanies categorical funding and develop ways to develop systems of care rather than categories of services.

## Essential Public Health Functions

To fulfill the Title V mission and promote collaborative systems building, State Title V programs engage in certain essential public health functions.

The Institute of Medicine in a 1989 report, *Toward the Future of Public Health*, recommended that public health agencies focus on three core functions. These include:

- Assessment
- Policy Development
- Assurance

The IOM suggested that public health agencies should envision as their responsibility the assessment of health status and the factors that influence health status, the formation of policy to promote and protect the health of the public, and activities to assure access to and the quality of public health services. This was meant to imply not that public health agencies are solely



responsible for the conduct of these activities but that they should take a leadership role and convening responsibilities to see the health of the public is protected and promoted.

Simultaneous to this work by the IOM, the AMCHP, in collaboration with the Federal MCHB and The Johns Hopkins University Child and Adolescent Health Policy Center, formulated *The Public Maternal Child Health Program Functions Framework: Essential Public Health Services to Promote Maternal, and Child Health in America*. This document helped provide a common framework for MCH programs across the country. The content is consistent with broader public health frameworks but is tailored to promoting MCH and serving CSHCN. Strong emphasis is placed on assuring availability, access, and quality of health services as well as on linkages with other systems serving women, children, youth, and families. Because the MCH essential services are adapted from the 10 essential public health services framework, they offer an important common language and bridge to broader public health efforts.

## **Ten Essential Public Health Services to Promote Maternal and Child Health and Existing and Potential Strategies for Providing These Services**

This section discusses the ten essential public health services and describes some of the ways that Title V is fulfilling these roles in Idaho. In addition, there is a discussion of some ways that Title V and its partners can continue to fulfill these essential functions in the future. To determine the state MCH Title V program's capacity to carry out the essential public health functions, AMCHP in collaboration with the MCHB and The Johns Hopkins University developed CAST-5. CAST-5 is a process used to identify the organizational capacity needs of the State Title V program and to specify ways to address these needs. CAST-5 was conducted during this needs assessment and is a natural and important complement to the findings described throughout this document.

### **1. *Assess and monitor maternal and child health status to identify and address problems.***

The Title V agency is responsible for assessing and monitoring MCH to identify and address problems. BOCAPS in Idaho has accomplished this through a variety of means including supporting an increase in the number of women surveyed through the PRATS survey. One need that was identified in this area was that local health districts are interested in being able to better assess and monitor MCH in their region. They do not feel that they have adequate data on health status at the regional level or their staff has the skills to conduct assessment activities. Enhancing existing data and providing more extensive training in assessment at the district level are additional ways that this essential service could be provided.

### **2. *Diagnose and investigate health problems and health hazards affecting women, children, and youth.***

One of the health problems BOCAPS is currently helping investigate relates to concerns over health complications that may be occurring when lay midwives deliver babies. There are many health problems that are surfacing in Idaho that need investigation including youth suicide, diabetes, and obesity. Efforts are occurring in a variety of these areas, and it will be important

that they result in recommendations that public health providers and their partners will be willing and able to implement.

**3. *Inform and educate the public and families about MCH issues.***

Some of the best examples of what has been done in this area are the activities around breastfeeding promotion. State and local councils helped develop program activities that served to educate the public about breastfeeding. These efforts have paid off in increased percentages of mothers who breastfeed their babies. There are lots of other areas where opportunities exist. For example, postpartum depression appears to be a serious problem in Idaho, and BOCAPS and its partners can play a role in educating the public and provider about this topic and what can be done to help relieve the problem.

**4. *Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve MCH problems.***

BOCAPS has participated in a wide variety of efforts to identify and solve maternal and child health problems. As noted, in years past the agency played a major role in developing Breast Feeding Coalitions around the State. In more recent years the agency has played more of a supportive role than a mobilizing role. While participation is important, there are some areas where BOCAPS may be needed to play more of a mobilization role. District Health Departments have expressed an interest in having a State staff person focused on MCH issues. BOCAPS may have a role in creating and enhancing partnerships among District Health Departments, CHCs, and Regional Health and Welfare offices.

**5. *Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families.***

Part of the reason that MCHB requires this 5-year needs assessment is to provide a tool that can be used in planning and policy development. However, there is a real need to ensure that such information is used for planning and policy development. As discussed in the system collaboration chapter, Idaho has created many planning bodies and task forces to address particular problems. At this point, there may be a need to step back and figure out how all the pieces fit together and where responsibilities lie for setting priorities in particular areas and among various populations.

**6. *Promote and enforce legal requirements that protect the health and safety of women, children, and youth and ensure public accountability for their well-being.***

The Title V agency and its partners have played a role in promoting legal requirements related to the use of seatbelts and child safety seats. Idaho's legislature is very reluctant to impose legal requirements that restrict individual behavior. However, there may be other ways to promote and enforce standards of behavior that protect health and safety. BOCAPS and its partners can develop recommended screening tools that providers can utilize to identify high-risk pregnant women or young children who may need assessment by the Infant-Toddler Program. By working with Medicaid, providers, and insurance companies, it is possible that such tools would win widespread adoption without being required by law.

**7. *Link women, children, and youth to health and other community and family services and assure access to comprehensive, quality systems of care.***

The use of Title V funds to support the Idaho CareLine is one of the ways in which families are linked to care in Idaho. Part of the responsibility for this function has shifted to the private sector Medicaid care coordinators. However, it is unrealistic to expect these coordinators to be effective without training and strong linkages to public sector health and welfare providers. Certification and training of these providers, especially in providing services to special populations, is needed in order for them to effectively link their clients to comprehensive services. Public health and its partners must fulfill this function for the new system to fulfill its function.

**8. *Assure the capacity and competency of the public health and personal health work force to address MCH needs effectively.***

BOCAPS helps sponsor a number of meetings that are designed to provide continuing education of health care providers. Despite this, District Health staff indicate that there is a need for opportunities for educating and training both new and continuing staff in providing public health services. Tools such as the Bright Futures publications may be useful in providing practical information that can strengthen the services offered by public health agencies.

**9. *Evaluate the effectiveness, accessibility, and quality of personal health and population-based MCH services.***

One way to improve the ability to evaluate the effectiveness, accessibility, and quality of services is to begin to include performance measures within contracts. It is important that such measures are carefully selected and can be used for program planning. Other programs, such as the Infant-Toddler Program, that have successfully used performance measures may be able to provide useful information on how to succeed.

**10. *Support research and demonstrations to gain new insights and innovative solutions to MCH-related problems.***

BOCAPS and its partners support such efforts through the collection of data that can be used to obtain funding for research and demonstrations and in the analysis phase of research and demonstrations. Other opportunities exist including having State and local staff serve as advisors to research and demonstration efforts. Program staff are often experts on services and know a great deal about what is happening in communities. They can serve as an excellent resource for researchers as they try and figure out how to address health and welfare challenges.

## CHAPTER V

### Pregnant Women and Mothers

---

#### A. Introduction

Healthy babies are most often born to women who were healthy prior to conception, wanted to become pregnant, do not smoke or drink, live in a supportive environment, obtained early prenatal care, and have adequate resources to support their physical, material, and emotional health. Medical conditions, poor health behaviors, and negative environmental conditions can be identified, treated, and/or eliminated prior to conception to improve the health of the woman as well as decrease the likelihood of a poor birth outcome.

#### B. Characteristics of Women in Idaho

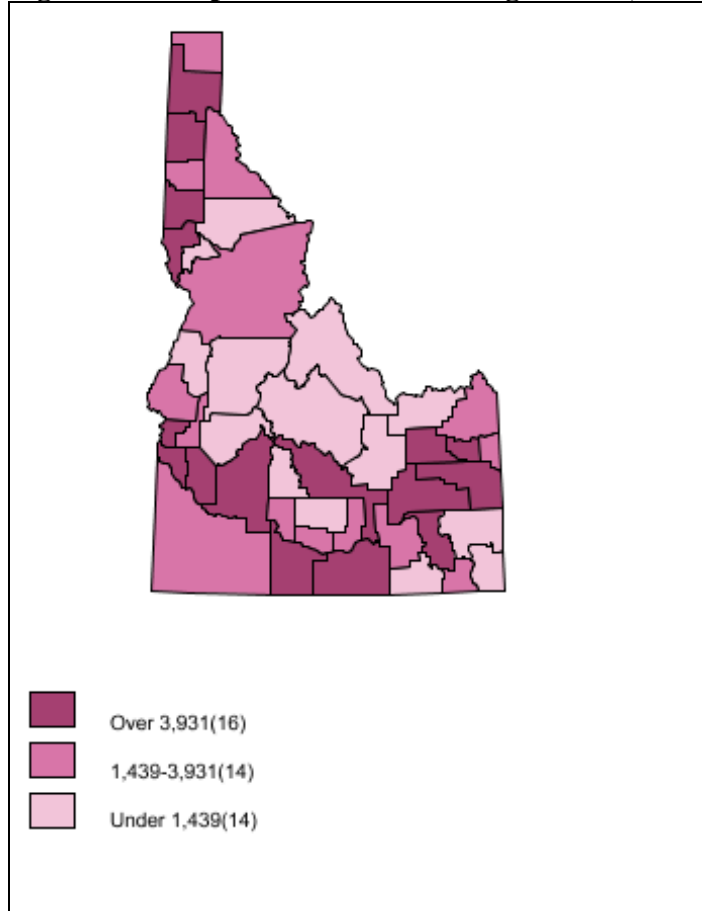
The distribution of race and ethnicity for women ages 15-44 mirrors the overall State demographic distribution. Non-Hispanic Whites account for 87.1 percent of the population, followed by Hispanic women at 9.3 percent. There are a small number of Native American, Asian, and Black women living in Idaho.

<b>Table V-1.</b>		
<b>Population of Women Ages 15-44 by Race or Ethnicity, Idaho, 2002</b>		
	<b>Percent</b>	<b>Count</b>
Hispanic	9.3	26,288
White	87.1	247,376
Black	0.5	1,430
Native American	1.5	4,384
Asian	1.6	4,640
Total	100	284,818

Source: March of Dimes 2005a (analysis of US Bureau of the Census. Population estimates for are projected from the 2000 Census based on bridged race categories, released by the National Center for Health Statistics.)

The women of childbearing age are concentrated in a few urban counties; given the rural and frontier nature of Idaho, there are 14 counties that have fewer than 1,439 women ages 15-44.

**Figure V-1: Population of Women Ages 15-44, Idaho, 2002**



Source: March of Dimes 2005b

The distribution by age among those 15-44 shows that almost 20 percent are teenagers.

<b>Table V-2</b>		
<b>Population of Women 15-44 by Age, Idaho, 2002</b>		
	<b>Percent</b>	<b>Count</b>
15-19	18.7	53,240
20-29	32.7	93,043
30-39	31	87,940
40-44	17.6	49,895
Total	100	284,818

Source: March of Dimes 2005b (analysis of US Bureau of the Census. Population estimates for are projected from the 2000 Census based on bridged race categories, released by the National Center for Health Statistics.)

Finally, 15.3 percent of Idaho women ages 15-44 have incomes below the 100 percent FPL. This is slightly more than the US average of 13.5 percent.

<b>Table V-3.</b>		
<b>Women Ages 15-44 Below FPL, Idaho and U.S., 2000-2002 Average</b>		
	<b>Idaho (Percent)</b>	<b>U.S. (Percent)</b>
Women 15-44	15.3	13.5

Source: March of Dimes. (2005c.)

Within this demographic context, the rest of the section explores women's health status and their access and utilization of health and social services.

### **C. Pregnant Women Outcomes Examined**

Three outcomes have been selected for in-depth examination for the Idaho Pregnant Women population. Achieving these outcomes will help to ensure that women are healthy and able to care for themselves and their families.

<b>Table V-4.</b>
<b>Idaho Pregnant Women Outcomes</b>
Women of childbearing age use ongoing preventive and primary care appropriately.
Pregnant women use early and adequate prenatal care.
Pregnant women use as appropriate the full range of enabling and support services to promote a positive pregnancy outcome.

#### **1. Women of childbearing age use ongoing preventive and primary care appropriately.**

*"I use doctors for my children but do not get medical care myself."*

*Migrant Head Start Staff*

Access to comprehensive, quality health services is an essential component of the health care system. To be accessible, services must be affordable, available, and within a reasonable travel distance. Also important is the quality and continuity of care available. This requires qualified staff able to provide a constellation of services that are delivered with respect and confidentiality.

#### **a. Health Insurance**

While there are a number of factors that influence health utilization, arguably none is more important in the United States than health insurance. When women are uninsured, they are more likely to postpone important preventive services such as Pap tests and go without filling prescriptions than their insured counterparts (Kaiser 2001).

The Kaiser Family Foundation describes Idaho's proportion of uninsured women as higher than the national average (20.1 percent to 17.7 percent). Although there is a larger proportion of low

income women in Idaho, compared to the United States, their rate of uninsured is about the same (see tables below).

<b>Table V-5. Health Insurance Enrollment of Women Ages 18 to 64, 2001-2002</b>				
	<b>Idaho</b>		<b>US</b>	
	<b>All Women (Ages 18-64)</b>	<b>Low-income* Women (Ages 18-64)</b>	<b>All Women (Ages 18-64)</b>	<b>Low-income Women (Ages 18-64)</b>
Estimated Number of Women (Thousands)	401	144 (35.8% of Total)	90,394	29,477 (32.6% of Total)
Percent with Private/Other**	71.3	43	73.7	42.6
Percent Medicaid	8.5	20.1	8.6	22.3
Percent Uninsured	20.1	36.9	17.7	35.2

\*Low income is defined as <200% of poverty, or \$30,040 for a family of 3 in 2002.

\*\*Private/Other category includes: employer-based coverage, other private insurance, and other public insurance, such as Medicare and military-related coverage.

Source: The Kaiser Family Foundation. (2005a). State level figures based on Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates using pooled March 2002 and 2003 Current Population Surveys. U.S total based on March 2003 Current Population Survey.

While the Kaiser data offer one estimate of the prevalence of the uninsured, the Idaho PRATS, a self-report mailed survey to women 3-12 months postpartum, reports for 2001 a much larger proportion of women without health insurance just before pregnancy.<sup>1</sup>

- More than 1 in 3 Idaho resident adult mothers (36.4 percent) reported that they did not have health insurance at the time just before pregnancy.
- The lower-income (<\$15,000) and Hispanic populations were more likely to lack insurance compared with mothers who have higher household incomes and/or are non-Hispanic Whites (IDHW, 2005a).

## **b. Health Insurance for Pregnant Women**

Lack of health insurance precludes many pregnant women from getting the prenatal care they need. In 2001, approximately 45 percent of women who reported not obtaining prenatal care as early as desired indicated that it was because they did not have enough money or insurance to pay for the visits (28.1 percent) or did not have a Medicaid card (17.0 percent) (IDHW, 2005a).

<sup>1</sup> The PRATS data is a valuable source of information about pregnancy health and has been utilized throughout this needs assessment. However, like other data sources, PRATS data has limitations. With self-report surveys, there is a potential for under- or overreporting. As importantly, the PRATS survey collects data 3-12 months postpartum, and some questions ask the respondent to remember events or behaviors up to 12 months before they were pregnant. Therefore, some mothers may be asked to remember events that happened 33 months earlier. Mothers who respond to the survey when their infant is younger may recall events more accurately than mothers who respond when their infant is older.

Pregnant women who fall under 133 percent of the Federal poverty guidelines can qualify for Idaho Medicaid's Pregnant Women and Children (PWC) program (also known as Low Income Pregnant Women Medical Assistance). In 2001, approximately 40 percent of Idaho resident adult mothers reported applying for Medicaid coverage during their pregnancy (IDHW, 2005a). Of these women, 16.2 percent reported being told they were not eligible for the program. Hispanic populations were more likely to report they were told they were ineligible for Medicaid services (34.2 percent) than non-Hispanic mothers (12.7 percent). Mothers aged 35 and older reported being told they were ineligible for Medicaid services (36.0 percent) more than any other age group (IDHW, 2005a).

The reasons cited for ineligibility require further examination. Hispanic focus group participants reported general confusion on residency requirements for Medicaid. While the Medicaid application states that a Resident Alien Card (if not a U.S. citizen) or other residency documents are required, one woman noted that undocumented pregnant women in Idaho cannot qualify for Medicaid to cover prenatal care expenses, only delivery. It was also stated that the State wanted to see an actual citizen card, not just clearance papers from immigration. The forthcoming PRATS 2002 data further examines the reasons women were told they were ineligible, and that information will assist the State in understanding issues related to misinformation or miscommunication about policy requirements.

Lack of adequate health insurance not only prevents women from receiving the prenatal care they need; it may also influence their decision as to where to deliver their infants. Focus group participants and key informants described the cost of hospital care as a major factor in choosing a home birth. Hospital delivery is approximately \$5,000, while in comparison the cost of lay midwife services for prenatal and delivery care is approximately \$1,000.

It is also interesting to note that in a study conducted by the Urban Institute and the Center for Studying Health System Change, to assess changes in Medicaid fees, Idaho reported only a 3.8 cumulative percentage change in Medicaid fees for obstetric care over the years 1998-2003. This compares to a U.S. cumulative percentage change of 10.2 percent for obstetric care (Zuckerman, 2004). The adequacy of reimbursement can have a direct effect on the ability of a provider to offer services to those with Medicaid insurance.

### **c. Medicaid Guidelines**

There are two major Medicaid programs in Idaho:

1. Title XIX AFDC-related coverage groups (Income is based on the AFDC Payment Standard in 1996). This includes the full package of Medicaid benefits.
2. Title XIX Medicaid coverage groups of Qualified Pregnant Women or Low Income Families with Children (Income is up to 133 percent of the Federal poverty guidelines). This includes pregnancy-related services only.



Both of these coverage groups are federally required. The Qualified Pregnant Women or Low Income Families with Children coverage group is known in Idaho as the Pregnant Women and Children program (PWC). Idaho is one of 13 states that chose not to expand coverage beyond the federal requirement (133 percent of poverty) for pregnant women.

PWC Coverage is limited to pregnancy-related and postpartum services. These include pregnancy testing, vitamins, lab and x-ray services, dental care, outpatient mental health services, OB/GYN visits, labor and delivery, and any other Medicaid services that the woman's doctor feels are medically necessary to ensure a positive outcome for the mother and baby. Nutrition, breastfeeding, and social support services are also included in the package of benefits. This package of services is not well understood or utilized by key-informant prenatal care providers. In particular, some providers reported that mental health services are not allowable services, even if prenatal or postpartum depression is indicated. Further investigation into the number of auxiliary service claims would be useful to understand better the breadth of care utilized.

PWC medical assistance coverage extends through the 60-day postpartum period if the woman applied for medical assistance while pregnant and was receiving medical assistance when the child was born. An individual who applies for PWC medical assistance after the child is born is not eligible for the 60-day postpartum period. In other words, unless women received prenatal care or were enrolled in health insurance during pregnancy, they are not able to receive any postpartum service. For these women, services that treat maternal and postpartum complications or screen for postpartum depression cannot not be provided.

A pregnant woman can obtain limited ambulatory prenatal care as a presumptively eligible (PE) pregnant woman through the end of the month after the month in which the provider completes the PE determination. PE coverage is designed to provide limited prenatal care during the time between the pregnancy diagnosis and the eligibility determination. A qualified PE provider, such as a District Health Office (DHO), accepts written requests for these services and completes the eligibility determination. The Central District Health Department is one provider who both is a PE provider and bills Medicaid for an abbreviated version of the high-risk PWC services. They know of no one else in the State who is performing such services. The number of geographic distribution of qualified PE providers is not available for this assessment.

The Idaho Medicaid Policy Team described how Medicaid supports enhanced services for high-risk pregnancies (key informant interview, October 2004). Health providers make the clinical determination whether the pregnant woman is experiencing a high-risk pregnancy. If so, she is able to receive two social-service visits, an additional two nutrition visits, two nursing visits, and a once-per-month risk-reduction visit. Guidelines are not Web posted or available through other established information venues, nor are they included in the provider or family manual. Broader awareness and utilization of this important resource could have very beneficial effects for the outcomes of high-risk pregnancies. Further investigation is also required to better describe the number of women who use these high-risk services and their pregnancy outcomes.

As of January 2005, the Medicaid Care Management Team instituted a new high-risk prenatal identification system and followup. The program integrates the Qualis Utilization Management

(UM) and Case Management (CM) services for the prenatal population. The UM service identifies pregnant women who have been in the hospital longer than 3 days, and for such patients, the CM service works closely with hospital discharge planners and in-home or community supports to move the patient out of the hospital and into her home. The Case Manager provides support by telephone, assisting the pregnant woman to get the services that she needs, and solving how to access outpatient, ongoing prenatal care. A pregnant woman can also be included in these case management services if referred by her doctor. This new initiative will be described in the January 2005 Medicaid newsletter and a letter will be sent to every provider who submitted an OB claim in the last year. This is a promising initiative that will better link pregnant women to necessary health services. There seems to be a disconnect between the Medicaid CM staff interviewed and the Medicaid Policy Team regarding this service as the case managers interviewed were not aware of the additional services high-risk women can access.

Further exploration is required to understand if women are aware of Medicaid eligibility guidelines and services available. To obtain prenatal care in the first trimester of pregnancy, the pregnant woman needs to begin the Medicaid application process as soon as possible. Currently, Medicaid does not fund any outreach program for eligible pregnant women. Furthermore, while the Medicaid application for assistance is easy to understand, there are no statewide materials that describe the benefits and rules for the PWC program to pregnant women who are low literacy. Materials in Spanish are available.

Another important Medicaid program is the Medicaid waiver for family planning as it affects women's access to care. The waiver serves to extend eligibility for Medicaid-covered family planning services to individuals who would otherwise not be eligible for such care. An evaluation commissioned by the Federal CMS documented that not only did these expanded programs provide critical contraceptive services as well as tests for cervical cancer, sexually transmitted diseases, and HIV for those who would otherwise not be eligible for such care, but they actually *saved* money for both the State and the Federal governments. Currently, there are 16 states that have a Medicaid family planning waiver. Idaho is not one of them (Gold, 2004).

#### d. State Policies and Practices for Private Insurance

The Henry J. Kaiser Family Foundation identifies specific State policies that include regulations to promote access to women's health services. The table below describes women's health services that some States regulate as mandated benefits of private insurers. Of the specific possible mandated benefits highlighted by Kaiser, Idaho mandates direct access to OB/GYN physicians and permits them to act as primary care providers.

<b>Table V-6 Idaho Mandated Benefits, Private Insurers</b>		
	<b>Idaho</b>	<b>U.S.</b>
Mandates Contraceptive Coverage?	No	21 Yes
Mandates Coverage of Mastectomy Stay?	No	20 Yes

<b>Table V-6 Idaho Mandated Benefits, Private Insurers</b>		
	<b>Idaho</b>	<b>U.S.</b>
Mandates Reconstructive Surgery After Mastectomy?	No	39 Yes
Mandates Osteoporosis Screening?	No	13 Yes
Mandates Chlamydia Screening?	No	3 Yes
Mandates Infertility Diagnosis and Treatment?	No	14 Yes
Mandates Direct Access to OB/GYNs?	Yes	40 Yes
Mandates that OB/GYNs can be Primary Care Providers?	Yes	17 Yes

Source: The Kaiser Family Foundation, 2005b.

#### **e. Family Planning**

It is important to examine access to and utilization of family planning services when assessing women's health. Not only is family planning utilization an indication that women are accessing preventive services; it also helps women and their partners to realize their family size goals and the timing of those goals. Furthermore, for every public dollar spent on family planning services, \$3 are saved in Medicaid costs for pregnancy-related and newborn care (Guttmacher, 2000).

- ***Number and Distribution of Family Planning Clinics in Idaho***

In 2003, there were 69 publicly supported family planning clinics in Idaho; 39 are administered by health departments, 5 by hospitals, 1 by Planned Parenthood, 18 by CHCs, and 6 by other types of agencies (Guttmacher, 2004).

Funding for Title X Supported Clinics, the Federal grant which provides for a range of reproductive health services for women and men who are at or below the poverty level, has increased slightly over the last 3 years. The State does not supplement Federal dollars. Of the 69 family planning clinics, approximately 40 are supported with Title X dollars. The DHOs administer most of these 40 clinics. Due to almost level funding, DHOs report that they are allocating resources from other projects to meet demand.

- ***Women Receiving Family Planning Services Prior to Pregnancy***

#### **Description of Need**

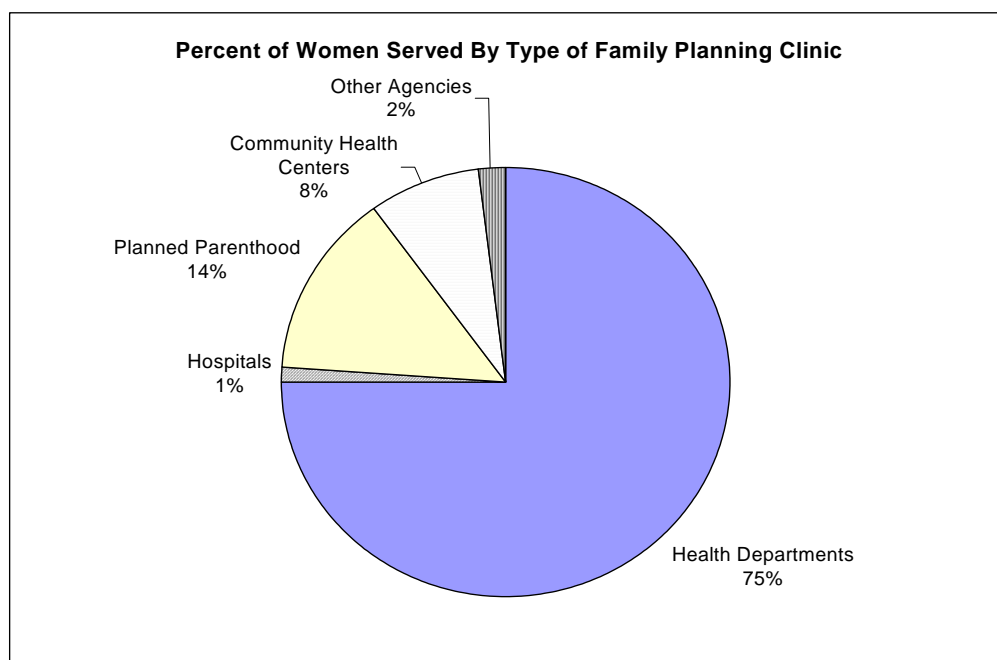
The Guttmacher Institute attempts to quantify the number of Idahoan women in need of contraceptive services and supplies (see <http://www.guttmacher.org/pubs/win/index.html>). Women are defined as "in need of contraceptive services and supplies" during a given year if they are aged 13-44 and meet three criteria: (1) they are sexually active, that is, they have ever had intercourse; (2) they are fecund, meaning that neither they nor their partner have been contraceptively sterilized and they do not believe that they are infecund for any other reason; and (3) during at least part of the year, they are neither intentionally pregnant nor trying to become pregnant.

According to Guttmacher, in 2002, there were 140,820 women in need of contraceptive services and supplies in Idaho. Of these, 80,360 women—including 22,380 teenagers—are in need of publicly supported contraceptive services (Guttmacher, 2004).

## Service Utilization

In 2001, family planning clinics in Idaho serve 41,720 women, including 12,890 teenagers. Seventy-five (75) percent are served by health departments, 1 percent by hospitals, 14 percent by Planned Parenthood, 8 percent by community health centers, and 2 percent by other types of agencies. Title X-supported clinics in Idaho served the majority of these women (37,090 out of 41,720). Of the total number of women served in Title X-supported clinics in Idaho, 11,300 are teenagers (see Figure V-2 below).

**Figure V-2: Percent of Women Served by Type of Family Planning Clinic, 2001**



Source: *Number of publicly funded family planning clinics and female clients served by type of provider, 2001*: AGI, special tabulations of AGI's 2001 census of all publicly funded family planning clinics, methodology and national data reported in Frost J, Frohwirth, L and Purcell, A, "The availability and use of publicly funded family planning clinics: U.S. Trends, 1994-2001," forthcoming in *Perspectives on Sexual and Reproductive Health*, 2004

In 2003, The Idaho Reproductive Health Program (Title X) provided education, counseling, and health services to more than 38,500 Idahoans.

In comparison to the United States average, Idaho has been successful in reaching its population in need of Title X services. In the United States, approximately 40 percent of the women in need of public services received them, while Idaho has served 50 percent of its target population (Table V-7).

<b>Table V-7</b> <b>Total Number of Women in Need of Contraceptive Services and Supplies, 2002;</b> <b>Number Served by Publicly Funded Clinics, 2001; and the Ratio*</b> <b>of Women Served to Women in Need of Public Services</b>				
	<b>Women in Need of Contraceptive Services and Supplies, 2002</b>		<b>Women Served at Publicly Funded Clinics, 2001</b>	<b>Ratio of Women Served to Women in Need of Public Services</b>
	Total	In Need of Public Services**		
US	34,241,690	16,776,730	6,663,570	40%
Idaho	145,110	83,120	41,720	50%

\*These ratios estimate the need that is met by clinics. They exclude women who receive Medicaid-covered services from private providers and users of nonprescription methods who have not visited a contraceptive service provider. In addition, they include some nonpoor women who are served by publicly funded clinics even though they do not fit the income definition of women in need.

\*\*Women in need of public services include adult women below 250 percent of the FPL plus all women younger than 20 who are in need of contraceptive services and supplies.

Source: Guttmacher, 2004

Although these numbers reflect the successful outreach and accessibility of current services, there may still be pockets of the Idaho community that are not well served. While Title X is reaching half the eligible population, it is unknown if the other 50 percent are receiving services. Latina women, in particular, are reported to have little access to family planning information. According to IPCA's focus group report, respondents stated that the high Latina teen pregnancy rate is due to the lack of education and family planning resources (Hakes, 2003).

- ***Prevention of Unintended Pregnancies***

The objectives set out by Healthy People 2010—to increase the percentage of intended pregnancies to 70 percent (Objective 9-1) and to increase the proportion of females at risk for unintended pregnancy (and their partners) who use contraception to 100 percent (Objective 9-3)—underscore the importance of preventing unintended pregnancies.

According to the Federal Office of Population Affairs, Office of Family Planning, with an unintended pregnancy the mother is less likely to seek prenatal care in the first trimester and more likely not to obtain prenatal care at all (Kost, 1998a). She is less likely to breastfeed (Dye, 1997) and more likely to expose the fetus to harmful substances, such as tobacco or alcohol (Brown, 1995). The child of such a pregnancy is at greater risk of LBW, dying in its first year, being abused, and not receiving sufficient resources for healthy development (Kost, 1998b). A disproportionate share of the women bearing children whose conception was unintended are unmarried or at either end of the reproductive age span—factors that, in themselves, carry increased medical and social burdens for children and their parents. Pregnancy begun without some degree of planning often prevents individual women and men from participating in preconception risk identification and management.

The consequences of unintended pregnancy are profound; however, it is very difficult to measure the intendedness because of how questions about “intendedness” are asked and whether point-in-time data can reflect the intendedness of the pregnancy accurately. In 2003 in Idaho, 1,779 women who went to a DHO for services reported not using a contraceptive method because they were currently pregnant. Of these, 1,105 (62.1 percent) stated the pregnancy was unplanned while 674 (37.9 percent) stated the pregnancy was planned (Family Planning Program, 2004). However, 3 months postpartum, only 37.5 percent of women reported their pregnancy was unintended at the time of conception (IDHW, 2005a).

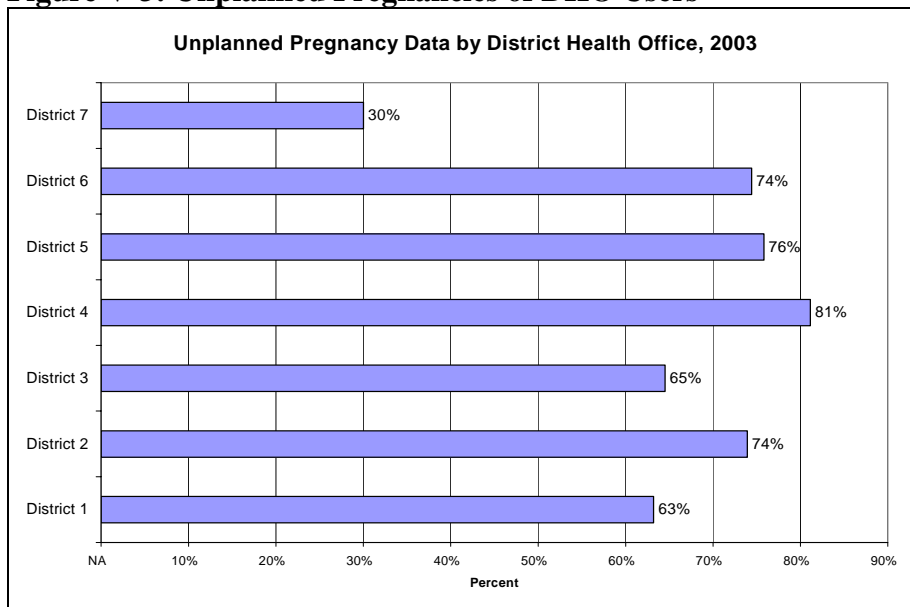
Most likely, there are several factors that contribute to these data differences. One is that the PRATS data is population based whereas the DHO is service-based information. Another factor is the point in time when the question is asked (i.e., when one first found out about being pregnant versus 3-12 months postpartum). A third factor is how the question was asked of the respondent. The words used may vary substantially among the DHO providers compared with the written words used in the PRATS survey.

Given the ambiguity of using intendedness of pregnancy as a predictor of birth outcomes, this assessment will examine unintended pregnancies as a measure of access and utilization of contraceptives.

In 1999, of the 17 States that participated in the PRAMS study (which is a retrospective study similar to the Idaho PRATS study), the prevalence of unintended pregnancy among women who had live births ranged from 33.7 percent (Utah) to 52.0 percent (Louisiana) (Beck, 2003). Idaho falls at the lower end within that continuum, with approximately one-third (37.5 percent) of Idaho resident adult mothers indicating that their pregnancy was unintended at the time of conception in 2001 (IDHW, 2005a).

Data from the DHOs reveal variations among age, ethnicity, and district. District 4 reported that 81 percent of the women who came to their clinic did not plan their pregnancy, while only 30 percent of women in District 7 reported the same (Figure V-3).

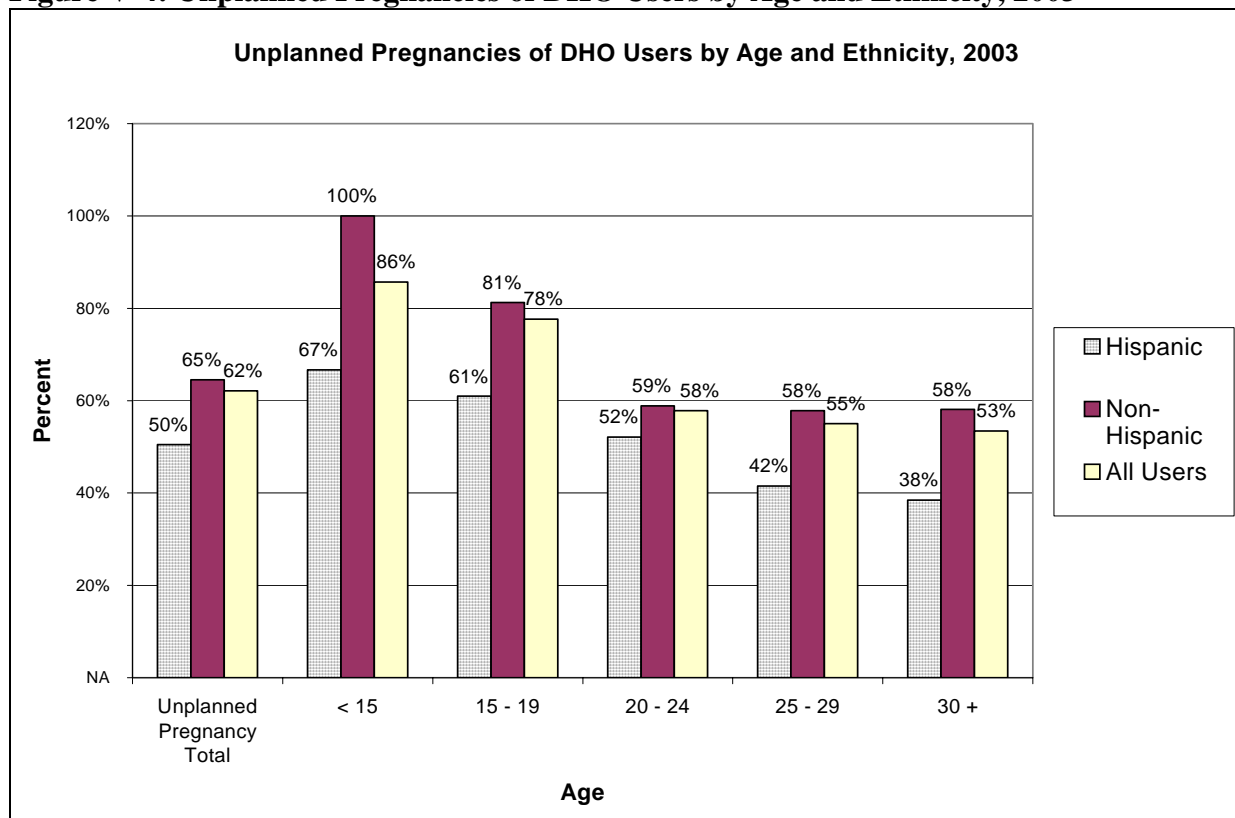
**Figure V-3: Unplanned Pregnancies of DHO Users**



Source: Family Planning Program, 2004

There were similar variations in planned pregnancies among age and ethnicity. Sixty-five (65) percent of non-Hispanic women reported the pregnancy to be unplanned as compared to 50 percent of Hispanic women. The difference by ethnicity was apparent for each of the age categories. As would be expected, there were less planned pregnancies among teenagers compared to women ages 20 and older. However, the data for Hispanic teens are worth noting. Approximately 33 percent of Hispanic teens under the age of 15 and 39 percent of Hispanic teens ages 15-19 reported that their pregnancy was planned.

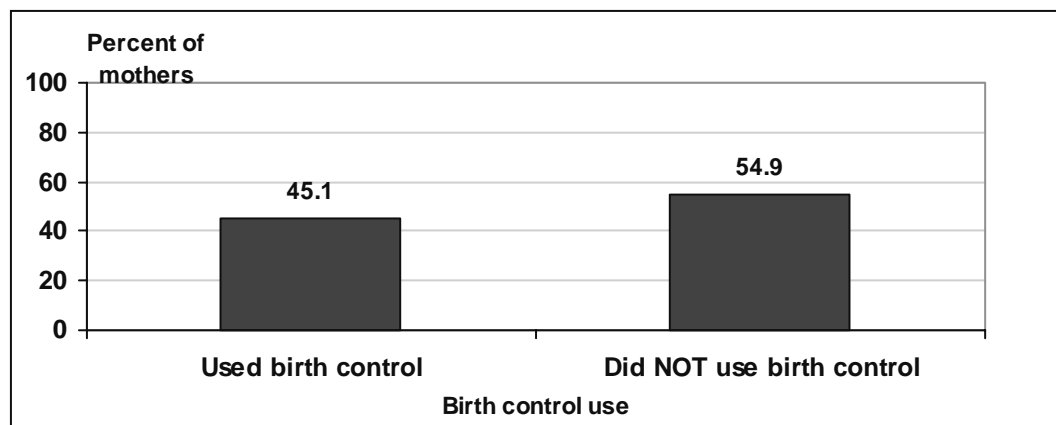
**Figure V-4: Unplanned Pregnancies of DHO Users by Age and Ethnicity, 2003**



Source: Family Planning Program, 2004

National PRAMS Data illustrated that in 1999, the prevalence of any type of birth control use at time of pregnancy among women who reported that their pregnancy was unintended ranged from 33.2 percent (Ohio) to 45.6 percent (Maine) (Beck, 2003). Idaho falls at the higher end of this range, with 45.1 percent stating they were using birth control at time of pregnancy (IDHW, 2005a) (Figure V-5).

**Figure V-5: Birth Control Utilization at Time of Conception Among Idahoan Mothers Not Trying to Get Pregnant in 2001**



Source: IDHW, 2005a



- **Abortions**

Induced abortion is another consequence of unintended pregnancy.

In Idaho in 2000, 27,460 of the 278,010 women of childbearing age became pregnant. Of these pregnancies, 74 percent resulted in live births, 10 percent in abortions, and 16 percent in miscarriages. The percentage of pregnancies resulting in an abortion in Idaho is substantially lower than the national average (Guttmacher, 2004).

The estimated pregnancy rate in 2000 among Idaho's 15- to 19-year-old women was 62 per 1,000. The State ranks 37<sup>th</sup> nationally. Of those pregnancies, 69 percent result in a live birth and 16 percent result in a miscarriage (Guttmacher, 2004).

The table below describes the number of induced abortions, the rate per 1,000 females by age bracket, and the ratio per 1,000 live births by age bracket. Across each of the categories, Idaho reports a lower rate and ratio of abortions compared to the United States.

<b>Table V-8.</b>					
<b>Induced Abortions in the United States and Idaho</b>					
	<b>Induced Abortions</b>	<b>Ratio per 1,000 Live Births</b>	<b>Rate per 1,000 Females Aged 10-14</b>	<b>Rate per 1,000 Females Aged 15-19</b>	<b>Rate per 1,000 Females Aged 15-44</b>
US 2000	850,293	246	2.0	17	16
Idaho 2002 (Residence)	1,493	71	0.2	6.1	5.3

Source: IDHW, 2004a (analysis of: "Abortion Surveillance - United States, 2000," Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, Vol. 52/No. SS-12, November 23, 2003)

The relatively low rate of abortions in Idaho may be due to a number of reasons. One is contraceptive use, as this is a key predictor of women's recourse to abortion. The group of American women who are at risk of experiencing an unintended pregnancy but are not using contraceptives account for almost half of all abortions—46 percent in 2000 (Guttmacher, 2004). Given that Idaho has been successful in reaching a larger proportion of its population with family planning services than the U.S. average, the Title X Program may be playing a pivotal role in avoiding unintended pregnancies. It is estimated that Idaho's publicly funded family planning clinics help women avoid 9,500 unintended pregnancies each year (Guttmacher, 2004).

Another possible reason for the low abortion rate may be due to the lack of access to legal abortion services. In 2000, there were seven abortion providers in Idaho. Ninety-three (93) percent of Idaho counties had no abortion provider, and 67 percent of Idaho women lived in these counties. In the Western U.S. census region, where Idaho is located, 19 percent of women having abortions traveled at least 50 miles and 6 percent traveled more than 100 miles to obtain this service (Finer, 2003).

Other reasons for the low rates may be the regulatory requirements placed on women seeking abortion or that many women travel out of State to have abortions and the abortions go unreported in Idaho. This service may be obtained out of State when the barriers to obtaining an abortion—such as gestational limits or expense—are lower in neighboring States.

#### **f. Nutrition**

Making healthy choices about nutrition contributes substantially to preventing illness and premature death (Frazao, 1999). Approximately 74 percent of the 2002 Idaho Behavioral Risk Factor Surveillance System (BRFSS) female respondents did not consume the recommended five servings of fruit and vegetables each day. The youngest age group (18-24) were the least likely to consume 5 or more servings a day (14.9 percent), and the oldest age group (65+) were most likely (38.6 percent) (IDHW, 2003a).

Vitamin and mineral supplement use is of particular interest for the health of women. There are specific circumstances during a woman's life cycle which are associated with special vitamin and mineral supplement needs (e.g., prior to conception, during pregnancy, and when at risk for certain health conditions such as osteoporosis). In 2001, approximately half (47.3 percent) of Idaho resident adult mothers reported taking a vitamin supplement during the 3 months before becoming pregnant. Almost all mothers (92.7 percent) reported taking vitamin supplements during pregnancy (IDHW, 2005a). Women were more likely to take vitamin supplements during the 3 months before becoming pregnant if the pregnancy was intended than if the pregnancy was unintended. Women were also more likely to take vitamin supplements during pregnancy if they reported being given information about the importance of taking vitamin supplements prenatally.

#### **g. Physical Activity**

Similar to healthy food choices, regular physical activity is essential for maintaining a healthy body, enhancing psychological well-being, and preventing a variety of chronic diseases and premature death. It is a concrete step Idaho women can take to keep themselves healthy. Unfortunately, physical inactivity is a significant problem among U.S. adults, contributing to a host of health risk factors and health conditions including obesity, hypertension, heart disease, diabetes, and cancer.

Nationally, men are more likely than women to participate in regular physical activity, and this is also true for Idaho. In 2003, females were significantly more likely to not participate in leisure time physical activity (20.1 percent) than males (16.5 percent). Rates decreased for both men and women with advancing age; 69.2 percent of women aged 65 and older reported being physically active compared to 84.4 percent of females aged 18-24 (IDHW, 2004b).

#### **h. Overweight and Obesity**

Overweight and obesity are linked to chronic conditions such as high blood pressure, heart disease, diabetes, and stroke. An expert panel convened by the National Institutes of Health used

height and weight measurements to define overweight as a Body Mass Index (BMI) of 25 kg/m<sup>2</sup> or greater and obesity as a BMI of 30 kg/m<sup>2</sup> or greater.

Using these definitions, according to the 2002 BRFSS, Idahoan adult females were less likely to be overweight than males (48.7 percent versus 65.7 percent). The Healthy People 2010 goal is to have 60 percent of adults at a healthy weight. Approximately 51 percent of Idahoan women are at a healthy weight. In 2002, in Idaho, women who were aged 18-24 were less likely to be overweight or obese, while those ages 45-54 and 55-64 were more likely to be overweight or obese. Almost half of Idaho women are either overweight or obese (IDHW, 2003a). The Idaho Diabetes Prevention and Control Program has launched programs to provide support to health care providers and their overweight patients. They have created publications that offer information and resources to physicians and other health care providers addressing the challenges of overweight and obese patients with and without diabetes in Idaho. Additionally, the Idaho Physical Activity and Nutrition Program has been launched to address obesity and other health related conditions caused by physical inactivity and poor eating habits.

#### **i. Breast and Cervical Cancer**

Important indicators of women's access to and utilization of primary and preventive services are the breast and cervical cancer screening rates and the proportion of cancer cases that are diagnosed in their early stages. This needs assessment will focus on screening and early stage diagnosis rather than cancer incidence and mortality.

The Cancer Registry of Idaho, along with the Women's Health Check, analyzed the breast and cervical cancer incidence, mortality, and screening data in Idaho and compared it to the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute.

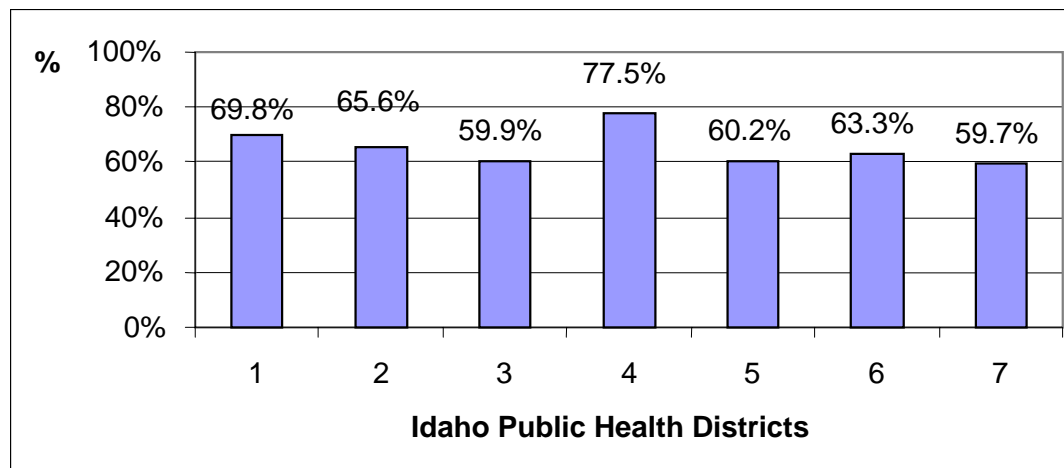
While many of the incidence and mortality data are similar to or lower than the national trends, screening data from the BRFSS coupled with stage distribution and stage-specific incidence rates strongly suggest that racial or ethnic discrepancies exist in Idaho in terms of diagnosing breast cancers early among younger women (aged less than approximately 55) (Johnson, 2004).

- ***Breast Cancer Screening and Staging***

The earlier breast cancer is detected, the less likely a woman will need highly invasive and uncomfortable treatments, and the more likely she will survive the disease. It is important to detect the disease in its earliest stages through screening mammography, clinical breast examination, and for women 20 years of age and older, breast self-examination. The Healthy People 2010 Objective 3-13 reflects this importance: to increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years to 70 percent.

In 2002, 67.0 percent of Idaho women aged 40 years and older had received a mammogram within the previous 2 years. However, breast cancer screening rates vary among Idaho's public health districts, ranging from a low of 59.7 percent in Health District Seven to 77.5 percent in the Central Health District (Johnson, 2004).

**Figure V-6: Mammogram During Past 2 Years, 2002, Women Aged 40 and Older (BRFSS)**



Source: Johnson, 2004 (analysis of BRFSS, 2002)

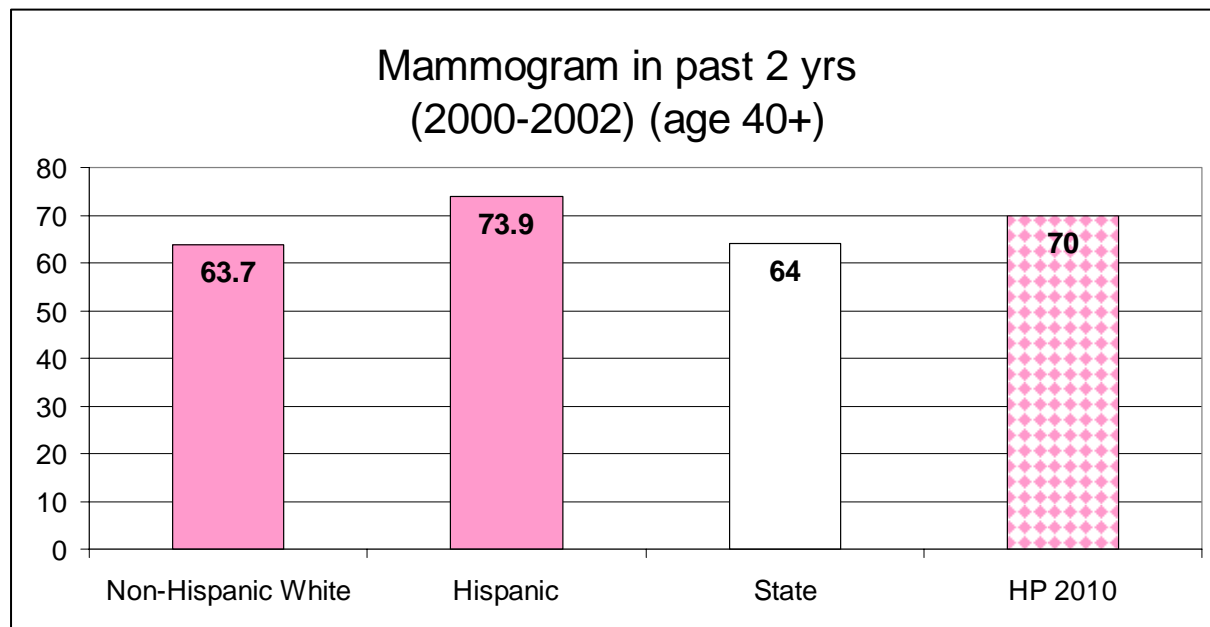
Breast cancer staging is the process of describing the extent of the disease or the spread of the cancer from the site of origin. Again, the earlier the diagnosis, the better the chance the woman will survive the disease. In Idaho, Hispanic women and uninsured women were more likely to be diagnosed with late-stage breast cancer. As described below (Table V-9), in 1998-2002, 37 percent of Hispanic women and 30 percent of non-Hispanic women were diagnosed with late-stage breast cancer in Idaho. In SEER regions, 1996-2000, 34 percent of Hispanic women and 28 percent of non-Hispanic women were diagnosed with late-stage breast cancers (Johnson, 2004).

<b>Table V-9.</b>		
<b>Late-stage Breast Cancer Diagnosis</b>		
	<b>Hispanic</b>	<b>Non-Hispanic</b>
Idaho (Years 1998-2002)	37%	30%
SEER (Years 1996-2000)	34%	28%

Source: Johnson, 2004

As described by the report *Health Care Access Barriers by Idaho Latinos*, Latina women lack knowledge regarding the importance of preventative screenings, such as Pap smears and mammograms, and access to receive them (Hakes, 2003). Paradoxically, Hispanic females reported similar rates of screening to their white female counterparts (Figure V-7).

**Figure V-7: Mammogram in Past 2 Years by Ethnicity, 2000-2002**



Source: Brett, 2004 (analysis of BRFSS, 2002)

Women with Medicaid or uninsured women were significantly more likely to have late-stage diagnoses compared with women with private insurance or Medicare. Among Idaho female breast cancer cases under age 65, stage at diagnosis was statistically significantly related to insurance status ( $p < 0.001$ ). For women aged 65 and older, over 90 percent have Medicare or private insurance, and about 25 percent of these cases have late-stage diagnoses.

- ***Cervical Cancer Screening (Pap Testing)***

Cervical cancer screening using the Pap test detects not only cancer but also precancerous lesions. Women should begin getting a Pap test with the start of sexual activity, but no later than at 18 years of age, and repeat the test at least every 3 years. Routine screening for cervical cancer can prevent many occurrences of this disease.

The Healthy People 2010 Objective is to increase the proportion of women who receive a Pap test to 90 percent. In 2002, 83.4 percent of Idahoan women reported receiving a pap test in the last 3 years (IDHW, 2003a). There was variation among districts, with 87.9 percent of females in District 4 receiving a Pap test in comparison to 78.1 percent in District 5. There are also significant differences by

- ***Age.*** Women aged 65 and older were significantly less likely to have received a Pap test in the last 3 years (62.7 percent).
- ***Income.*** Women with household incomes greater than \$50,000 were significantly more likely to have had a Pap test in the last 3 years (91.0 percent). By comparison, those with incomes less than \$15,000 were 4.4 times less likely to have had a Pap test (79.9 percent).

- **Insurance Coverage.** Females not having had a Pap test within the last 3 years were 2.3 times more likely than those receiving a Pap test to not have health care coverage.

Screening data from the BRFSS coupled with stage distributions strongly suggest that an age-related discrepancy exists in Idaho in terms of diagnosing cervical cancers late among older women (Johnson, 2004).

- **Women's Health Check**

The Women's Health Check program is charged with improving the rate of breast and cervical screenings. It contracts with health providers to coordinate screening and diagnostic services for eligible women throughout Idaho. In addition to screening, the Women's Health Check Program partners with others to provide breast and cervical cancer education and outreach opportunities and clinical breast exam training for health care professionals. Over the last 3 years, the program has experienced a fifty percent increase in the number of screenings; however, it is anticipated that by 2005, program capacity will be reached.

<b>Table V-10.</b> <b>Women's Health Check, Number of Women Screened</b> <b>for Breast or Cervical Cancer</b>	
<b>State Fiscal Year</b> <b>7/1-6/30</b>	<b>Number of Unique Women Screened</b>
2004	3003*
2003	2487
2002	2214
2001	2097

\*Numbers are not finalized.

Source: Women's Health Check Program, 2004

It would be useful if future analyses included county (or health district)-specific age and ethnicity data to further explore the disparities described above.

#### j. Oral Health

According to self-reported BRFSS data, 44.6 percent of Idaho adults lacked dental insurance in 2003. There were significant differences by age, with 77.3 percent of those over age 65 without dental insurance (IDHW, 2004b). The BRFSS described how males were significantly more likely not to have visited a dentist in the previous 12 months (36.0 percent) than females (31.7 percent). Adults 65 and older were significantly less likely to have visited a dentist in the previous 12 months (40.4 percent) than those in younger age groups (IDHW, 2004b).

Over the last decade, there was very little change in the percentage of the adult population who had not received annual dental care by visiting a dentist. In 2003, 33.8 percent of adults had not visited a dentist within the previous 12 months. Health Districts 1 and 3 had significantly higher percentages of the adult population who did not visit the dentist in the previous 12 months (37.9

percent and 41.5 percent, respectively). Health Districts 4 (25.9 percent) and 7 (29.8 percent) had significantly lower percentages (IDHW, 2004b).

In pregnancy, there is an increased risk for certain oral diseases (e.g., gingivitis), and recent research suggests a potential association between maternal periodontal (gum) disease and risk for preterm delivery, which in turn increases the risk of having an LBW baby.

In 2001, women 3-12 months postpartum described their oral health practices during pregnancy (IDHW, 2005a):

- Sixty-six (66) percent of mothers reported that their prenatal health care providers did not tell them about the importance of getting regular dental care during their most recent pregnancy.
- Sixty-three (63) percent of mothers reported that they did not go to a dentist or dental clinic for routine dental care during their most recent pregnancy.
- Twenty-three (23) percent of mothers who did not get dental care during their most recent pregnancy reported that they did not feel getting dental care was important.

#### **k. Mental Health**

An assessment of women's health is not complete without an examination of the social, emotional, and environmental factors that contribute to her health and well-being. The issues of mental health, substance abuse, domestic violence, and their co-occurring interplay are often not included in health assessments. However, from a preventive, public health perspective, this holistic approach is essential.

- ***Mental Health and Well-being***

A woman's mental health is vital to her personal well-being, her ability to parent, and her ability to have positive family and interpersonal relationships. A continuum of mental health services includes promotion of mental wellness, prevention of mental health problems, and treatment of mental illness.

In the United States, nearly twice as many women (12.0 percent) as men (6.6 percent) are affected by a depressive disorder each year (Reiger, 1993). Depressive disorders include major depression, dysthymic disorder (a less severe but more chronic form of depression), and bipolar disorder (manic-depressive illness). In Idaho, the rate of death by suicide among women is much higher than it is nationally, at 6.2 per 100,000 in Idaho and 4.0 in the United States in 1999-2001 (Caiazza, 2004).

State mental health systems primarily focus on individuals with acute mental illnesses and creating a system to treat them. Most States use a variation of the American Psychiatric Association's DSM-IV to define their target population, usually categorized as having serious

mental illness (SMI) or severe and persistent mental illness (SPMI). Experts estimate that 5.4 percent of the U.S. population have SMI and 2.6 percent have SPMI.

Idaho's Mental Health Program targets individuals with SPMI, as defined by when a person has schizophrenia, schizoaffective disorder, major affective disorder, delusional disorder, or a borderline personality disorder; and that this psychiatric disorder is of sufficient severity to cause a disturbance in role performance or coping skills in at least two of these areas on either a continuous or an intermittent (at least once per year) basis: vocational or academic, financial, social or interpersonal, family, basic living skills, housing, community, or health.

Utilizing vital statistics information, the Department of Health and Welfare estimated that in 2002 there were approximately 1,200 individuals in Idaho with SPMI, an increase of almost 5 percent from 2000 to 2002 (Mental Health Program, 2004). SMI and SPMI are more clearly defined than mild-to-moderate feelings of anxiety, depression, and stress that, if left untreated, can have life-threatening consequences to the individual and her family. The Idaho Behavioral Risk Factor Surveillance System and the Idaho PRATS are data sources that provide some understanding of these mental health problems.

In 2003, 43.4 percent of females in Idaho reported poor mental health. This is in comparison to the national average of 38.3 percent. (Table V-11)

<b>Table V-11. Percent Reporting Poor Mental Health during the Past Thirty Days by Gender, 2003</b>		
	<b>Idaho</b>	<b>US</b>
Male	30.3	29.1
Female	43.4	38.3

Sources: The Kaiser Family Foundation, 2003.

In 2001, the Idaho Department of Health and Welfare conducted a study to take a more in-depth look at mental health among Idaho women of childbearing age. The results showed that 37.2 percent of women aged 18-44, and 23.6 percent of pregnant women, thought they might be depressed (Table V-12). Of those, 32.1 percent of nonpregnant women reported being diagnosed with depression, and 0 percent of pregnant women reported being diagnosed. Although the numbers of pregnant women were small in this study, 17 percent sought help from family or friends and 9 percent from a therapist or counselor for any mental or emotional problems, yet none were diagnosed with depression (IDHW, 2003b).

While it is not entirely clear what the lack of pregnant women in the study experiencing depression who were diagnosed means, the finding does indicate the importance of exploring further the mental health needs of pregnant women given that approximately 10 percent of women will experience depression during the prenatal period. It is important to intervene during pregnancy to help avoid the debilitating, long-lasting negative effects of postpartum depression, which can impact adversely the woman, her partner, and their newborn.



Other interesting findings from this study include that of the women diagnosed with depression, 96.1 percent received treatment, with the vast majority of them (68.8 percent) being treated by the family doctor. A psychologist or psychiatrist treated 20 percent of those diagnosed, and only 11 percent received treatment from mental health centers, groups, religious counselors, or family or friends (IDHW, 2003b). It is unknown whether some women received treatment from multiple providers. The course of treatment the family doctor provides, including whether medication is combined with talk therapy and/or referrals to community resources, is not known, nor is the comfort level of these providers in addressing the mental health issues of their patients. Of the 6.1 percent of women who needed treatment but didn't receive it, the most stated reason was financial or that insurance didn't cover the associated costs.

<b>Table V-12.</b>					
<b>Mental Health Among Idaho Women of Childbearing Age, 2001</b>					
<b>In the past year, the respondent:</b>	<b>Population</b>	<b>Percent</b>	<b>Confidence</b>		<b>N</b>
Sought help from family or friends for any mental or emotional problems	Women, 18-44	29.4	26.3	32.5	1,275
	Pregnant Women	17.0	4.7	29.2	77
Sought help from a therapist, counselor, or self-help group for any mental or emotional problems	Women, 18-44	15.1	12.7	17.5	1,275
	Pregnant Women	9.0	0.0	19.8	77
Thought she may have depression	Women, 18-44	37.2	34.0	40.5	1,272
	Pregnant Women	23.6	10.3	37.0	77
Was diagnosed with depression <i>among those who thought they may have depression</i>	Women, 18-44	32.1	27.0	37.1	474
	Pregnant Women	0			
Received treatment for depression <i>among women who were diagnosed with depression within the last year</i>	Women, 18-44	96.1	92.9	99.3	160
	Pregnant Women	0			
Had this person treat the depression <i>among women who received treatment for depression within the last year</i>	Psychologist or Psychiatrist	20.2	12.3	28.1	152
	Family Doctor	68.8	59.9	77.8	152
	Other*	11.0	5.0	16.9	152
Needed treatment for any mental or emotional problems during the last 5 years but was unable to get it	Women, 18-44	6.1	4.5	7.7	1,273
Had this reason for inability to get treatment for her mental or emotional problem	Cost Too Much or Insurance Didn't Cover	86.1	79.1	94.1	76
	Embarrassed or Stigmatized	4.8	0.0	9.7	76
Attempted suicide within the last year	Women, 18-44	1.0	0.0	1.9	1,273

\*The Other category includes Mental Health Center, Self-Help groups, family or friends, and religious counselors.  
Source: IDHW 2003b

The Division of Health is also utilizing the PRATS surveillance system to explore the prevalence of postpartum depression. The survey is completed via mail by women approximately 3-12 months after the delivery of their baby. Sixty point nine (60.9) percent of Idaho resident adult mothers reported being at least a little depressed during the 3 months after the delivery of their new baby (IDHW, 2005a).

Given the stigma of depression, especially among new mothers, the Division of Health supplemented the standard depression question in the PRATS survey with the Postpartum Depression Screening Scale (PDSS) Short Form. The PDSS consists of seven questions to assess degree of symptoms of postpartum depression. This scale was included in the 2002 Hispanic PRATS and the 2003 PRATS (which provides statewide and district-level estimates).

Results from the 2002 PRATS study indicated that 63.1 percent of non-Hispanic mothers and 79.4 percent of Hispanic mothers had significant symptoms of postpartum depression (PRATS PPD Special Report). Furthermore, 2.5 percent of non-Hispanic mothers and 4.8 percent of Hispanic mothers indicated that they either agreed or strongly agreed with the statement, “I have thought that death seemed like the only way out of this living nightmare” (Idaho Department of Health and Welfare, 2004d).

Analysis of the 2002 Hispanic PRATS indicates that women were at higher risk for symptoms of postpartum depression if they had one or more of the following characteristics:

- Low income
- Unintended pregnancy
- LBW baby
- Low education attainment for age
- Not married at time of delivery

PRATS data also showed that a higher proportion of women have significant symptoms of postpartum depression at 12-15 weeks postpartum and then again at 32-35 weeks postpartum.

Similarly, the findings of the Latino focus groups commissioned by the Idaho Primary Care Association echoed the PRATS and BRFSS data. As described by one health provider, “There is a lot of need for emotional assistance to deal with Latina women’s stress, domestic violence, abuse, and fighting.” Mental health issues reported by the focus group respondents included depression, stress, domestic violence, ETOD abuse, and “Nervios” (Spanish term for anxiety). The literature cites that Latinos, particularly migrant farm workers, experience high levels of stress, anxiety related to employment, and lack of social support. All contribute to the above problems (Hovey, 2002).

Almost 40 percent (164) of the Family Health Survey respondents stated they needed help for feeling depressed or nervous during pregnancy. Of those, about 27 percent never sought help; 50

percent sought help and found it useful; and 17 percent couldn't find help or, once they found it, did not find it useful.

- ***Mental Health Capacity***

The Adult Mental Health Services Program in the Idaho Department of Health and Welfare focuses its efforts on individuals who have SPMI. In addition, they will serve any individual 18 years of age or older who is experiencing an acute psychiatric crisis, including suicidal and/or homicidal behavior, and who may end up in an inpatient psychiatric facility if mental health intervention is not provided promptly. Only short-term treatment or intervention, not to exceed 120 days, is provided to this population.

For those with SPMI, the following core mental health services are provided: (1) Screening, (2) Targeted Case Management, (3) Crisis Intervention, (4) Psychiatric Rehabilitation, (5) Assertive Community Treatment, (6) Psychiatric Services, and (7) Short-term Mental Health Intervention.

For FY 2004, 10,684 clients were enrolled in services and 7,586 were “unenrolled” (Mental Health Program, 2004). If the estimates cited (approximately 25,000 individuals with SPMI) are accurate reflections of the needs of the population, the Department of Health and Welfare is serving approximately 68 percent of the eligible population. Data are not available on clients served by race or ethnicity or the comprehensiveness of the services provided.

For the population not receiving services through Idaho's Adult Mental Health Services, there is a shortage of mental health professionals and mental health services. Every county in Idaho is deemed a Mental Health Professional Shortage Area. In 2000, there were 580 psychologists in the State (Department of Health and Human Services [DHHS], 2004).

Other preventive mental health services include postpartum depression support groups that are often provided through the larger hospitals, and Parents as Teachers (PAT). While PAT's primary goal is parent-child interaction and school readiness, it has an additional mental health promotion component.

Screening for psychosocial risk factors by physicians and other types of providers is an important tool for early intervention in management of mental health problems. Idaho does not have in place guidelines for mental health screening and no protocol for the coordinated response to an identified mental health problem. The availability of training and support for primary health care providers in screening and treating mental health issues is an important topic that deserves further exploration.

## **I. Alcohol, Tobacco, and Other Drugs**

The negative health consequences associated with smoking, alcohol, and other drug use are well documented. The use of these substances by women in Idaho and the availability of intervention services are the focus of this section.

- ***Cigarette Smoking***

Nationally, the percentage of women who smoke, a behavior associated with numerous chronic illnesses, has remained steady over the last several years at slightly more than 20 percent of women aged 18 and older (Brett, 2002). In Idaho in 2003, 25.9 percent of females aged 18-24 reported smoking cigarettes within the past month. In this age group, slightly more females than males reported smoking in the past month (25.9 versus 23.8 percent). However, women ages 25-34 were less likely than men to have smoked in the previous month. For both sexes combined, cigarette smoking was most prevalent among adults aged 25-34 (23.8 percent) and 35-44 (26.2 percent) and decreased with increasing age to 8.5 percent of individuals aged 65 and older (IDHW, 2004b).

Maternal smoking during pregnancy is associated with ectopic pregnancies, miscarriages, LBW, and infant mortality. There was a decrease from 1999 to 2001 in the proportion of mothers who reported cigarette smoking during the 3 months prior to becoming pregnant from 23.6 percent in 1999 to 19.7 percent in 2001. Non-Hispanic White women were more than twice as likely to smoke during pregnancy as Hispanic women (10.2 versus 4.6 percent) (IDHW, 2005a).

Idaho birth records indicate much lower rates for smoking during pregnancy than when women were asked 3-12 months postpartum. Risk-specific data is often underreported on the birth certificate; nevertheless, the data does reflect variation among Regions. Only 9 percent of mothers in Region 3 reported smoking during pregnancy in comparison to 20 percent of mothers in Region 1 (State of Idaho Substance Abuse Social Indicators, 2003).

<b>Table V-13.</b> <b>Percent of Live Births with Tobacco Use as a Risk Factor During Pregnancy,</b> <b>3-year Average, 2001-2003</b>			
	<b>Total Live Births</b>	<b>Number of Births Where Mother Reports Tobacco Use</b>	<b>% of Births Where Mother Reports Tobacco Use</b>
Region 1	2,276	446	20
Region 2	1,126	169	15
Region 3	3,049	379	11
Region 4	5,469	477	9
Region 5	2,581	342	13
Region 6	2,713	285	11
Region 7	2,738	274	10
State Total	19,954	2,373	12

Source: State of Idaho Substance Abuse Social Indicators

Rather than examining the prevalence of smoking during pregnancy, the Family Health Survey focused on the respondents' perceptions and behaviors about seeking help to stop smoking. The survey revealed that 15 percent of respondents reported needing help during pregnancy to quit smoking. Of those, 18 percent did not seek help, 15 percent sought help but did not find it useful, and 51 percent found useful help.

- ***Alcohol Misuse***

In 2003, 7 percent of females and 24.7 percent of males aged 18 and older reported binge alcohol use in the previous month, defined as having 5 or more drinks on the same occasion at least once in the month prior to the survey. Additionally, 1.4 percent of females and 9.4 percent of males aged 18 and older reported heavy alcohol use in the past month, defined as having 5 or more drinks on the same occasion on 5 or more days within the month prior to the survey (IDHW, 2004b).

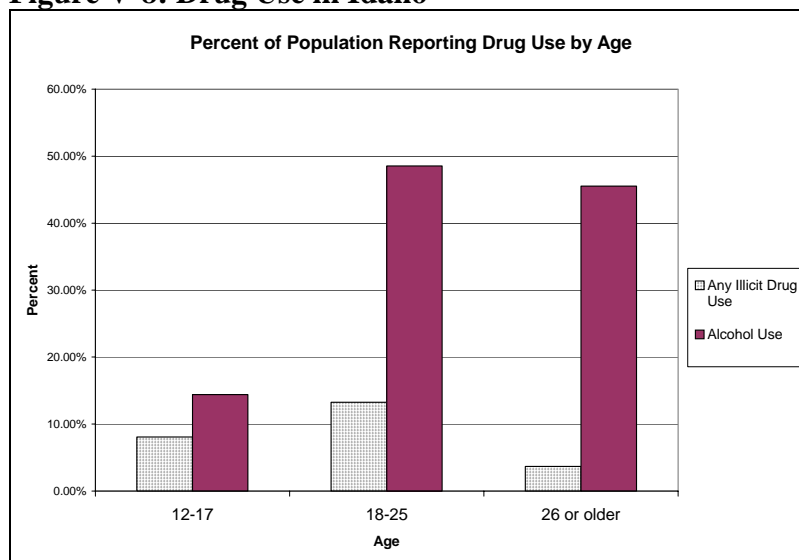
Alcohol misuse appears higher among young adult women than among their older counterparts. Among women 18-24 years old in 2003, 13.6 percent reported heavy drinking in the past month. Females in other age groups reported lower rates of binge drinking. After age 25, binge alcohol consumption declined significantly for both males and females. For heavy drinking, no significant differences among female age groups were reported. Among women aged 15-44, there did not appear to be differences among Hispanic and non-Hispanics. More data are needed to explore these behaviors among other racial and ethnic groups in Idaho (IDHW, 2004b).

Drinking alcohol during pregnancy contributes to Fetal Alcohol Syndrome (FAS), LBW, and developmental delays in children. There is little data in Idaho that provides a description of the prevalence of alcohol use during pregnancy. Birth certificate data is one avenue, however it is probably underreported. The State 3-year average (2001-2003) was 0.73 percent, with a high of 1.43 percent in Region 1 and a low of 0.40 percent in Region 4 (State of Idaho Substance Abuse Social Indicators, 2004).

- ***Illicit Drug Use***

Because of the potential risk for misuse and addiction, marijuana or hashish, cocaine, inhalants, hallucinogens, heroin, and prescription-type psychotherapeutic drugs used for nonmedical purposes are classified as illicit drugs in the United States. In Idaho in 2003, 10.9 percent of women aged 18-25 had used some type of illicit drug within the past year. There did not appear to be differences in use among Hispanic and non-Hispanic women.

**Figure V-8: Drug Use in Idaho**



Note: Percent using in last 30 days

Source: State of Idaho Substance Abuse Social Indicators, (Analysis of National Household Survey on Drug Abuse, 2003)

In a survey of law enforcement, judges, probation officers, prosecutors, and public defenders within each county, 97.1 percent of respondents felt that methamphetamine use was one of the most harmful drugs in their area (Idaho State Police, 2003a). The number of methamphetamine laboratories seized per year per county shows that there are heavy pockets of activity. In Kootenai County, there were 107 labs seized between January 2000 and January 2004.

- ***Drug and Alcohol Prevention and Treatment***

The Department of Health and Welfare has a well-developed, regionalized drug and alcohol prevention system. Each region conducts a yearly Prevention Needs Assessment and develops corresponding priorities. Through a State-sponsored Web site, providers can access resources on community needs, develop services based on best and promising practices, and measure effectiveness through outcome evaluations and other research tools. Furthermore, the annual Idaho Prevention Conference brings together service providers and policy makers to learn about innovative strategies including specific sessions on alcohol and drug prevention.

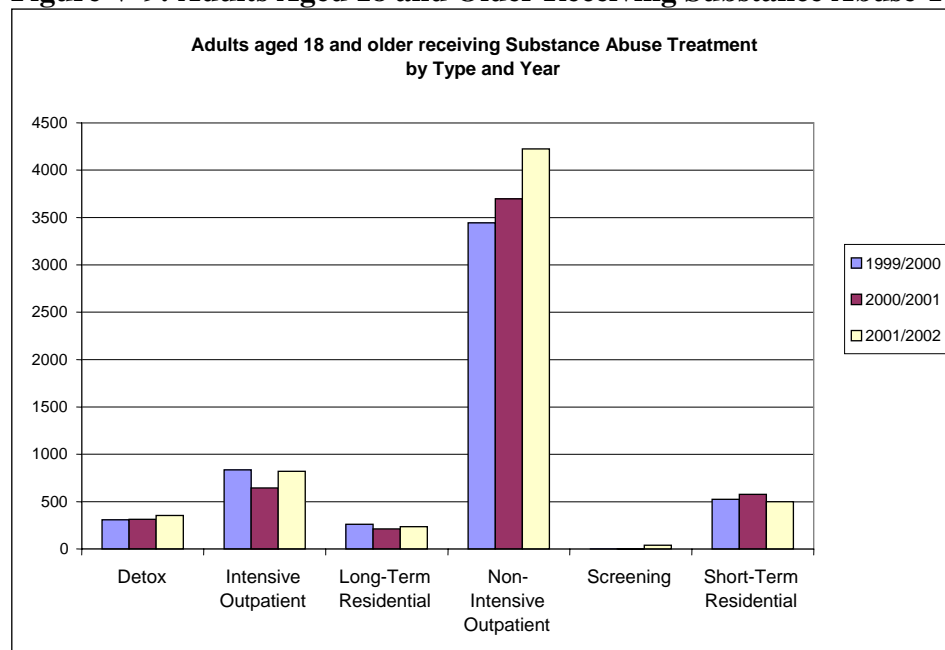
From 1999-2002, the Department of Health and Welfare served approximately 5,200 adult clients per year in Public Treatment Programs. For State FY 2003, the rate per 1,000 adults ranged from 1.9 in Region 4 to 4.5 in Region 2 (Table V-14). The majority of the clients received nonintensive outpatient followed by intensive outpatient care (Figure V-9). Alcohol was listed as the primary drug of abuse, followed by methamphetamines and then marijuana.

As reported by the Idaho Department of Health and Welfare, methamphetamine addiction in adult and adolescent populations continues to rise in the state. Sixteen (16) percent of adult clients reported methamphetamine as their primary drug choice in 1997. This use steadily increased to 23 percent in 2000, with an alarming 34 percent adult usage in 2004 (State of Idaho Substance Abuse Social Indicators, 2004).

Table V-14. Idaho State Rate per 1,000 Adults in Idaho by Region				
	State Fiscal Year			
Region:	99/00	00/01	01/02	02/03
Region 1	4.2	3.8	3.7	4.0
Region 2	3.8	4.0	3.9	4.5
Region 3	5.8	5.0	4.4	3.8
Region 4	2.5	2.3	2.5	1.9
Region 5	2.6	3.0	3.9	3.5
Region 6	3.0	3.2	3.7	3.5
Region 7	4.1	4.1	5.1	4.0

Source: State of Idaho Substance Abuse Social Indicators, 2004

**Figure V-9: Adults Aged 18 and Older Receiving Substance Abuse Treatment**



Source: State of Idaho Substance Abuse Social Indicators, <http://www.class.uidaho.edu/sasi> (analysis of IDHW Client Information System)

It is critical that providers identify chemically dependent pregnant women and a support system is in place for her to detoxify and stay clean. The impact of substance abuse on the developing fetus, and a woman's ability to parent, is well documented. Key informants indicated that although there is an emphasis on treatment for pregnant women, few services are actually available.

As the table below describes, there are nine facilities in Idaho that specifically served pregnant or postpartum women. All nine provided outpatient services, two provided partial hospitalization or

day treatment, and only one provided residential treatment. Of the nine, two had a sliding fee scale and only one offered payment assistance.

Substance abuse is a major co-occurring problem for adults with mental disorders. Evidence supports combined treatment, yet this type of treatment is difficult to find in many communities. In Idaho, of the nine facilities for pregnant women, only three provided a mix of mental health and substance abuse services. Two of the three were located in Idaho Falls.

<b>Table V-15. Substance Abuse Facilities for Women and Pregnant Women in Idaho</b>		
	<b>Women</b>	<b>Pregnant/ Postpartum Women</b>
<b>Substance Abuse Services</b>	25	9
<b>Substance Abuse - Mental Health Services</b>	8	3
<b>Type of Care</b>		
Outpatient	23	9
Partial Hospitalization or Day Treatment	5	2
Residential Short-term Treatment (30 Days or Less)	4	1
Residential Long-term Treatment (More than 30 Days)	4	1
Hospital Inpatient	0	0
<b>Forms of Payment Accepted</b>		
Medicaid	9	2
Sliding Scale	11	2
Payment Assistance	3	1

Source: SAMHSA, 2005.

It should be noted that Medicaid does not reimburse for inpatient mental health or substance abuse treatment.

#### **m. Violence Against Women**

Violent crimes include rape, sexual assault, robbery, and aggravated and simple assault.

Violent crimes are perpetrated by strangers, friends, acquaintances, other relatives, or intimate partners. Women are more likely to be the victims of violent acts committed by intimate partners.

The majority of sexual assaults and rapes also occur among women. In 2001, respondents to the Idaho Crime Victimization Survey reported more sexual assaults and rapes than in 2000. Rates increased 39.2 percent in 2000 (from 8.4 to 11.7 per 1000 households) and 91.6 percent in 2001 (from 11.7 to 22.4 per 1000 households). The survey also revealed that 77.1 percent of sexual assault and rape incidents and 54.1 percent of nonsexual assault incidents were not reported to police (Stohn, 2003).



According to the survey, the rate for crimes of domestic violence decreased 38.6 percent from 43.0 per 1,000 persons 18 or older in 2000 to 26.4 per 1,000 persons 18 or older in 2001. Children were present in 52.5 percent of domestic violence incidents. Survey respondents also indicated that 59.7 percent of domestic violence incidents were not reported to the police. Reasons for not reporting domestic violence were:

- It is a private matter (48.6 percent)
- Police would do nothing (17.1 percent)
- Abuse would get worse (2.9 percent)
- Combination of other reasons (31.4 percent) (Stohr, 2003).

According to police report data, which only contain information about crimes reported to the police not all perpetrated crime in Idaho, there were 36,693 documented incidents of domestic violence from 1995 to 2001, 79.5 percent of which were committed against women. Age patterns for intimate partner violence peaked between the ages of 25-34 years (Idaho State Police, 2003b).

- ***Domestic Violence in Pregnancy***

In 2001, women who were 3-12 months postpartum were asked if anyone pushed, hit, slapped, kicked, choked, or physically hurt them during the 12 months before they got pregnant and during their most recent pregnancy. One (1) in 15 mothers (6.5 percent) reported that they were physically abused during the 12-month period before pregnancy. Nearly 1 in 20 mothers (4.2 percent) reported that they were physically abused during pregnancy (IDHW, 2005a).

The risk of physical abuse during the 12-month period before pregnancy was higher for specific groups (IDHW, 2005a):

- ***Young Women.*** Idaho resident mothers 18 to 24 years of age (11.8 percent) compared with mothers 25 years of age and older (5.7 percent).
- ***Women with Low Education Attainment.*** The risk of physical abuse during the 12-month period before pregnancy was higher for Idaho resident adult mothers with low or average education attainment for age (9.4 and 9.1 percent, respectively) than for mothers with high education attainment for age (4.0 percent).
- ***Unmarried Women.*** The risk of physical abuse during the 12-month period before pregnancy was higher for women who were not married (19.6 percent) than for married women (3.8 percent).

Service providers often feel uncomfortable screening for domestic violence because they do not know how to ask about it and are often unprepared to deal with clients' responses. Just over one-third of Idaho resident adult mothers who received prenatal care (37.1 percent) were given information about physical abuse to women by their husband or partner by a doctor, nurse, or

other health care provider (IDHW, 2005a). It would be useful if health care institutions, agencies, and private practices had guidelines for screening, patient education, response processes, and referrals.

#### **n. Other Health Issues**

Idaho has one of the lowest rates of female death due to cancer and heart disease in the country. It is one of the few States in which women have already met the Healthy People 2010 target for reducing deaths due to colorectal cancer. It also ranks high in terms of physical activity. However, Idaho ranks as one of the lowest States in the Nation in the percentage of women receiving cholesterol screenings, routine checkups, or regular mammograms and pap smears (Brett, 2004).

- ***Diabetes***

While there are many other health topics and concerns for women, diabetes requires special note. Diabetes is a chronic condition and a leading cause of death and disability in the United States. Complications from diabetes include loss of vision, kidney failure, heart disease, limb amputations, and nerve damage, conditions which can both shorten the life span and diminish the quality of life.

In 2003, the prevalence of adult diabetes was 6.3 percent, having increased by 50 percent since 1994. Females aged 65 and older were more likely to have been diagnosed with diabetes (12.7 percent), and the percentage having been diagnosed with diabetes increased with each age group (IDHW, 2004b). In Idaho, death rates due to diabetes based on a 3-year average (2000-2002) were twice as high for Hispanics when compared to non-Hispanics and non-Whites compared to Whites (Idaho Diabetes Prevention and Control Program, 2004).

The report, *Health Care Access Barriers for Idaho Latinos*, echoed this finding, saying, “Diagnosis of Diabetes is a death sentence” (Hakes, 2003). The report goes on to note that diabetes is a serious problem in the State and more resources are needed to raise awareness about prevention and treatment among the Latino community.

Diabetes is also a problem in the Native American community with the disease reaching epidemic proportions. Nationally, 14.5 percent of the population receiving care from Indian Health Services (IHS) has diabetes (American Diabetes Association, 2005). Several Idaho tribes have implemented obesity prevention and diabetes control programs.

At the State level, the Idaho Diabetes Prevention and Control Program works to increase the awareness of individuals and providers about the prevention and treatment of diabetes. The program produced educational materials in both Spanish and English and has also established the Diabetes Alliance of Idaho. This Alliance created a directory of providers offering specific diabetes services. There is a diabetes specialist in each of the DHOs to offer support and education.

## **2. Outcome: Pregnant women use early and adequate prenatal care.**

For women to receive quality prenatal services, they must have easy access to a system of comprehensive, coordinated health services. The case study of the South Central DHO provides an example of the struggles to create a comprehensive, coordinated system of quality prenatal care.

The South Central DHO serves pregnant women through the WIC Program, family planning clinic, and smoking cessation classes and provides pregnancy testing and referrals for prenatal care clients. Staff recognize the need for other community services, such as prenatal and parenting classes, but the community lacks the resources to provide them

The South Central District has the second lowest rate of first trimester prenatal care in the State (74 versus 82 percent). This is most likely due to the lack of providers who accept Medicaid. Other physicians, it is believed by the District Director, will not provide services until Medicaid eligibility has been determined. At one time, the WIC program used to screen for Medicaid “pre-eligibility” but found it did not expedite the process for Medicaid enrollment. Now they give brochures and refer those who appear to be eligible to the Department of Health and Welfare.

While the District staff has attempted to engage physicians in forums to discuss this issue, physicians do not attend them. Additionally, the local labor and delivery hospital has shown no interest in addressing this problem. The District would like to conduct a local assessment to truly understand the barriers to care and develop a plan to address them, but they lack the resources to do so.

The South Central DHO is not unique in its frustration related to a lack of a system of care for families. From each stakeholder’s perspective, there are perceived barriers to getting needed services. There are hospital staff that are looking for ways to engage women in prenatal classes, there are Medicaid staff who are working hard to expedite PWC eligibility, there are families who are being denied early prenatal care services, and there are doctors who are overloaded and cannot find the psychosocial services their patients need.

This section examines many of these issues in more detail.

### **a. First-trimester Prenatal Care**

The percent of Idaho births where prenatal care was initiated in the first trimester was comparable to the national average, 81.7 percent in Idaho versus 83.7 percent in the United States (see table below). This overall comparison masks the differences by race, ethnicity, and age. The rate for the non-Hispanic White population in Idaho is slightly lower than the rate for the non-Hispanic White population in the United States. The same holds true for the Hispanic population across each age category. Because Idaho has a predominantly White population, the lower rates for other races and ethnicities have less effect on the overall rate in Idaho. There are also significant entry-to-prenatal-care differences among health districts, with the range being from 71.8 percent in District 1 to 88.8 percent in District 4.

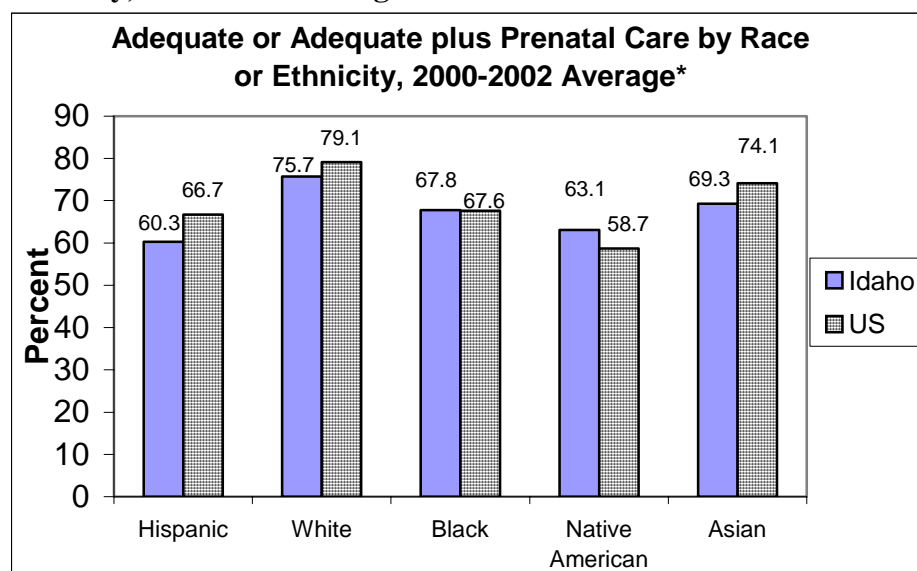
<b>Table V-16.</b> <b>Proportion of Women Who Initiated Prenatal Care in the First Trimester</b>			
<b>Source</b>	<b>Idaho Vital Statistics (2002)</b>	<b>Idaho Vital Statistics (2001-2003)</b>	<b>U.S. Vital Statistics (2002)</b>
<b>ALL</b>	<b>82.1</b>	<b>81.7</b>	<b>83.7</b>
<b>Race</b>			
White	82.5	82.1	85.4
Black	82.7	83.7	75.2
American Indian	71.0	69.4	69.8
Asian or Pacific Islander	83.5	82.7	84.8
<b>Ethnicity</b>			
Hispanic	70.2	69.3	76.7
<b>Districts</b>			
District 1	71.8		
District 2	86.0		
District 3	77.4		
District 4	88.8		
District 5	74.2		
District 6	84.2		
District 7	86.1		
<b>Ages</b>			
<15		45.5	48.2
15-19		64.7	70.0
20-24		79.8	78.6
25-29		85.3	86.3
30-34		86.6	89.8
35-39		80.0	89.2
40+		77.8	86.3

Source: IDHW, 2004c, and National Center for Health Statistics

## b. Adequacy of Prenatal Care

The adequacy of prenatal care by race or ethnicity reflects data for first trimester care, namely, that within each race or ethnicity category Idaho is lower than the national average for Hispanics, Whites, and Asians, yet higher for Native Americans.

**Figure V-10: Adequate or Adequate Plus Prenatal Care by Race or Ethnicity, 2000-2002 Average**



\*Adequacy is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into one of four categories (inadequate, intermediate, adequate, and adequate plus) by combining information about the timing of prenatal care, the number of visits, and the infant's gestational age. Source: March of Dimes, [www.marchofdimes.com/peristats](http://www.marchofdimes.com/peristats) (analysis of National Center for Health Statistics, final natality data)

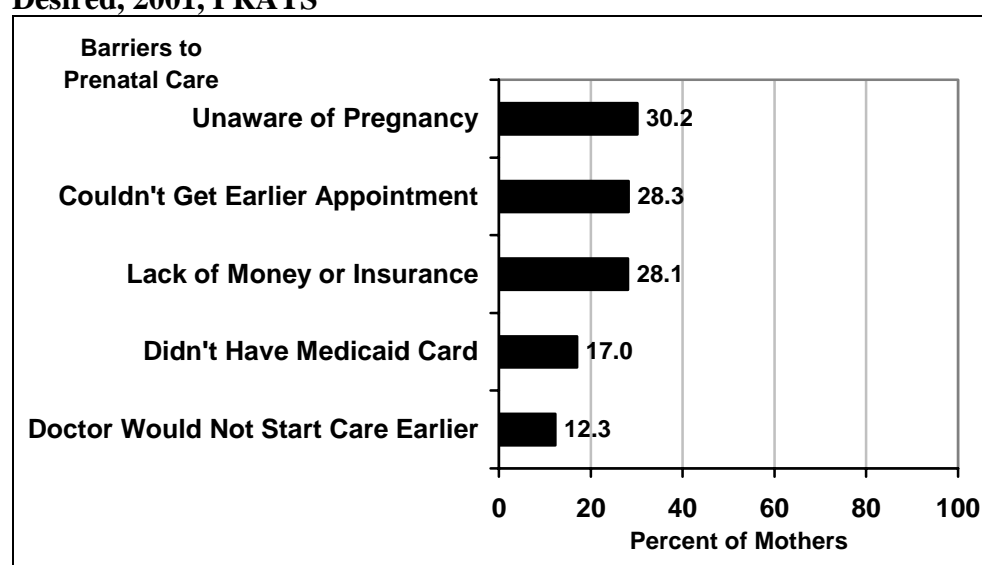
Key-informant interviewees and focus group participants identified a variety of barriers to accessing early and adequate prenatal care. First, the distances that need to be traveled and the lack of transportation, particularly in rural areas, to obtain care are prohibitive. Second, many women lack insurance and do not have the money to pay for associated out-of-pocket expenses. Third, key informants questioned if women valued prenatal care particularly after the first pregnancy or if some women only seek care when they are ill.

Most Idaho Family Survey respondents either did not need help finding prenatal care (57 percent) or found such help to be useful (39 percent). Very few respondents described looking but not being able to find prenatal care. While it was not possible to assess whether they received early and adequate prenatal care using objective measures, respondents clearly did not perceive finding care as a serious concern. Interestingly, however, 238 out of the 359 respondents (66 percent) stated they needed help paying for prenatal care. Of those, 188 respondents (79 percent) were able to find payment help, and 9 percent needed help but did not seek it.

While many service providers in Idaho question whether pregnant women value prenatal care, in 2001, mothers self-reported that the issue is more about access than values. Results indicate that 80.8 percent of Idaho resident adult mothers received prenatal care as early in their pregnancy as they wanted. Of those who were able to access care when they desired, 95 percent were able to do so in the first trimester. Of the 19.2 percent of mothers who did not receive prenatal care as early in their pregnancy as desired, 66.3 percent actually did receive care in the first trimester. If there was a question of valuing care, we would perhaps see a smaller percent of mothers receiving care early (IDHW, 2005a).

Instead, PRATS data suggests that women do not receive services as early as they desire because they were unaware of the pregnancy (30.2 percent), were not able to obtain an appointment earlier (28.3 percent), lacked money or insurance (28.1 percent), did not have a Medicaid card (17.0 percent) or the doctor would not start care earlier (12.3 percent) (IDHW, 2005a) (see graph below).

**Figure V-11: Reasons Cited that Kept Women from Getting Prenatal Care as Early as Desired, 2001, PRATS**



### c. Quality of Prenatal Care

Traditional quality measures for obstetrics include the week of pregnancy at which the mother entered prenatal care and the baby's birth weight, Apgar scores, and gestational age at birth. However, those measures do not evaluate how effectively a system addresses issues such as poverty, dysfunctional family environments, smoking and substance abuse—all of which can have a negative impact on pregnancy. The rest of this section examines the management of high-risk pregnancies and what system is in place to meet the physical and psychosocial needs of high-risk pregnant women.

- ***Identifying and Serving High-risk Pregnancies***

All hospital and prenatal staff interviewed as key informants indicated that they screened for medically high-risk pregnancies and for the high-risk women identified trying to arrange for the delivery to occur in a hospital with a neonatal intensive care unit. There does not appear, however, to be a statewide system of transfer or referrals in place from Level I nurseries to Levels II and III.

Providers in small rural hospitals experience particular problems in dealing with high-risk pregnancies. They are often required to work in multiple departments of the local hospital and

report being “stretched too thin.” There are very few OB/GYNs in the rural communities, and most physicians are general practitioners with hospital delivery privileges.

Although routine high-risk medical screening and referrals are reportedly conducted, no one interviewed for the assessment could identify a specific high-risk screening tool that is promoted or used. As described earlier, the Central DHO is the only provider identified during this assessment as providing intensive prenatal services. Each woman receives a comprehensive risk-reduction assessment and the appropriate followup education or counseling services. On the DHO’s own initiative, they are looking at ways to identify pregnant women based on risk factors, and triage them to an appropriate level of care. Their goal is to create a high-risk identification process so they can be most efficient with their limited resources and better provide patient-centered care. Some providers described the lack of services for socially high-risk pregnant women as a particular problem. Most did not feel they knew of any resources in the community that could provide additional supports or services the women may need.

While Idaho Medicaid’s policy is to identify high-risk births among recipients and arrange for them to have additional prenatal visits and extra monitoring, most direct service providers interviewed did not know of this Medicaid initiative or the potential additional visits for such women. Interestingly, even the Central DHO was not aware that there was a specific category of services available for high-risk pregnant women via Medicaid.

Since pregnant women with HIV are considered high-risk, it is important to describe the process of identification of these women. The State of Idaho follows CDC guidelines that recommend universal counseling and voluntary HIV testing of all pregnant women. There is no specific law or regulation regarding testing for mothers and newborns. In 2001, approximately half (49.0 percent) of Idaho resident adult mothers indicated that they were tested for HIV during their pregnancy. One (1) in 6 mothers (16.1 percent) was unsure whether she had been tested for HIV. Nearly one in three mothers (35.0 percent) indicated that she had not been tested for HIV (IDHW, 2005a).

- ***Cultural Competency***

For a health system to be effective, patients must feel that providers respect their culture and language and recognize the context and complexity of their lives.

While many think of cultural competency in terms of language, race, or ethnicity, Idaho has a somewhat different set of circumstances that need to be understood and embraced. In Idaho, there is a growing number of Hispanics and a small but strong Native American community. There are also families that choose to live in frontier counties. Many are fiercely independent and wary of government intervention. There also are many families where religion and spirituality have a profound importance and are significant sources of health and well-being.

There are both protective practices and potentially harmful practices among different cultures, and it is the health provider’s role to acknowledge all of the varying cultural healing practices,

even if they are not understood, and come to mutually acceptable and understandable interventions for care.

In the needs assessment's focus group, the overwhelming majority of Hispanic mothers rated the prenatal care they received as very poor. They shared accounts of being left for hours in the examination room and of not being told they had a high-risk pregnancy but later finding out it was in their medical charts. One woman reported that a doctor performed a C-section earlier than the due date because he had to go on vacation early.

A hospital-based childbirth educator described how PAT trained Latina women to be peer mentors and how this initiative has been very successful in increasing knowledge about healthy behaviors and parenting in culturally acceptable ways. She thought the same type of peer counseling should be implemented during pregnancy.

Providers also explained that many women seek the services of a midwife. They choose this partly because of cost and partly because they want their birth to be less “medicalized.” With very few opportunities to use the services of a certified nurse-midwife (CNM), many women opt for direct-entry or lay midwives, some of whom are certified while others are not. Two rural hospitals indicated that the presence of CNMs on staff would be an enormous benefit to families enabling them to reach out to families and assure safe birth practices that met their cultural needs. One urban provider described hoping to develop partnerships with birthing centers so women would be more likely to seek prenatal care.

The desire of some women to use the services of a midwife provides an example of Idaho's challenge in supporting culturally competent care. The medical community is grappling with how to regulate and interact with direct-entry midwives. There are reports that when midwives bring a failed home birth to the hospital, they are often treated poorly by staff and blamed for the medical emergency. This treatment, rather than encouraging a partnership, discourages midwives from coming to the hospital. Some hospitals, on the other hand, are trying to bring direct-entry midwives into their circle of care through supervision and training embracing nonjudgmental attitudes.

Deciding the best course of action requires a better understanding of why people are choosing home births and how women and providers can come to mutually acceptable health practices.

- ***Service Coordination***

Most focus group participants reported receiving early and adequate prenatal care and also felt that the information they received from their health provider was useful. There were some critical exceptions, however, to the positive experiences reported. For example, women who obtained prenatal care in a clinic setting saw different providers for each visit, interfering with continuity of care. This made it difficult to establish a relationship with a provider and ensure that the provider was fully aware of the woman's status.



An area for further exploration is the referral mechanism and information sharing between the family planning clinic and prenatal care providers. Many women learn they are pregnant at the family planning clinic. Family planning data indicates that 62.1 percent of the pregnant women who come to the family planning clinic had an unplanned pregnancy. For such women, the family planning clinic may be the first point of entry into the health care system and moving them on to a prenatal provider is essential. Given that the family planning clinic conducts a full health assessment, with the women's consent the resulting information could be provided to the prenatal provider to better assure continuity and quality of care.

Interestingly, the Central DHO has created this referral mechanism with one group of obstetrical providers. When a woman comes to the family planning clinic for a pregnancy test and the pregnancy confirmed, staff assist her in applying for Medicaid's PWC and conduct a risk reduction assessment. Once she prequalifies for Medicaid, the DHO helps arrange the first prenatal visit with an obstetrician. Importantly, the DHO is trying to develop a system that will link the postpartum mother back into the family planning clinic after her 60-day postpartum eligibility ends. They see this as a critical piece of continuing care for her and helping assure that the next pregnancy is planned.

Another potential opportunity is coordination between WIC and prenatal care providers. Approximately 34 percent of women participated in WIC during their pregnancy. In particular, WIC seems to be effective in reaching the Hispanic population, with 62.1 percent of Hispanic mothers reported having participated in WIC during pregnancy. Furthermore, thirty (30) percent of WIC participants enrolled during their first trimester of pregnancy. Given that a large proportion of Hispanic women, in particular, are not receiving adequate prenatal care, WIC may be a vital gateway into the health system.

Exploring the coordination and referral mechanisms between WIC and Medicaid provides insight into some of the system coordination issues that are typical to the State system of care. It should be noted that Idaho is not unique in these system issues. Nevertheless, the WIC-Medicaid example is illustrative of system barriers.

The WIC Procedure Manual states that referrals must be provided to every participant. Referrals include Medicaid, food stamps, SCHIP, immunizations, drugs and other harmful substances, and other referrals as needed. The WIC data system captures referrals made to Medicaid or other programs, but there is no mechanism in place to conduct followup to the referrals in the system. It is left to the discretion of each WIC clinic to develop a procedure for referral followup. Most of the followup is on an ad hoc basis and not necessarily documented. Health providers are given information only on a case by case basis, and information is not routinely shared. If information is shared, it is usually about the special feeding needs of a child.

There is not a designated person or central liaison in WIC or Medicaid. When WIC staff have questions regarding Medicaid eligibility, they often get passed around from person to person at Medicaid. Furthermore, Medicaid staff are very busy and often do not have time to answer WIC-related questions. WIC staff, for their part, are unfamiliar with the scope of services provided

through Medicaid and how the Healthy Connections program works. From WIC's perspective, Medicaid staff are unaware of the scope of WIC services.

WIC believes that joint training, where local level staff from both Medicaid and WIC learn about one another's programs, would go a long way in helping both to recognize and pursue opportunities for coordination.

**3. Outcome: Pregnant women use as appropriate the full range of enabling and support services to promote a positive pregnancy outcome.**

**a. Prenatal Classes**

Prenatal and childbirth classes are primarily offered in urban areas. For the most part, classes are taught by certified childbirth educators in urban areas. In the rural areas, where there are fewer health providers, the availability of classes is much more variable and classes that do exist are usually taught by labor and delivery nurses rather than certified childbirth educators.

Both rural and urban key informants report that it is very difficult to engage pregnant women in childbirth classes. In the rural areas, women usually have to travel far to participate, although urban hospitals report a similar lack of participation in childbirth classes. They hypothesize that pregnant women perceive the birthing classes to focus primarily on pain management, and because they are opting for an epidural at birth, they do not see the value of the classes. Further study needs to be conducted to understand better what type of information expectant parents want and how best to provide it.

A little over half of the Family Health Survey respondents described needing and receiving information on what to expect regarding pregnancy and childbirth, advice on healthy eating, and what to do when the baby arrives. Most who sought information found it helpful. Only about 5 percent of families found the information unhelpful.

**b. WIC**

WIC is implemented by 9 agencies, with over 60 clinic sites. In 2003, WIC served 64,438 clients, 19,111 which were pregnant women or mothers. The majority of participants (75 percent) had family income levels 130 percent or less of the federal poverty guidelines.

<b>Table V-17.</b>		
<b>WIC Family Income Levels, 2003</b>		
<b>Income Levels</b>	<b>Number of Families</b>	<b>Percent</b>
0-130%	18,419	75
131-150%	2,302	9
151-185%	3,645	15
Total	23,066	100

Source: Idaho WIC, 2002.

Participants in the focus groups conducted as part of this assessment who were enrolled in WIC reported satisfaction with the services. They received useful nutrition and breastfeeding information and necessary subsidies. Interestingly, the Hispanic focus group participants had a somewhat different perspective about WIC. They received important information on breastfeeding and nutrition, yet many of them had lived in other States before coming to Idaho and reported that while other State WIC programs provide classes on child development and parenting, Idaho WIC is limited to nutrition education. They described how in California, WIC assesses for child development delays and if a problem or issue is identified, extra developmental services are provided. They saw this as a very important service that was lacking in Idaho.

### c. Early Head Start

Just 2 percent of eligible pregnant women were enrolled in Idaho's Early Head Start compared to the national average of 12 percent (Idaho Head Start Association, 2004). Although fewer pregnant women in Idaho were enrolled in Early Head Start than women across the United States, they fared better in Idaho's programs. They were more likely to receive all four main prenatal services, especially mental health and substance abuse services. This increased utilization of services is especially critical considering that a greater proportion of Idaho's pregnant women were "medically high risk" than the United States (Table V-18).

**Table V-18: Selected Characteristics of Pregnant Women Enrolled in Early Head Start During the 2002-2003 Program Year**

Characteristics	Idaho	U.S.
Enrollment	1.7%	12%
Under 18 years of age	20.3%	24%
With health insurance	86.4%	85%
Pregnancies defined as "medically high risk"	32.2%	24%
Received the following services:		
Prenatal and postpartum care	100%	94%
Mental health and substance abuse interventions and followup	61.0%	28%
Prenatal education on fetal development	98.3%	92%
Information of benefits of breastfeeding	98.3%	93%
Received dental exams	37.3%	No data

Sources: Idaho data is from the Idaho Head Start Association, 2004, and national data is from CLASP, 2004.

## Summary Findings and Analysis

### Women of childbearing age use ongoing preventive and primary care appropriately.

#### Summary

- Approximately one in three women in Idaho reported lack of health insurance prior to pregnancy.
- Many women lack access to comprehensive, affordable health care before, during, and after pregnancy. Many women who hold private insurance have high deductibles that make care too expensive. For those on Medicaid, pregnancy-related services are narrowly defined and not universally understood.
- There is confusion around eligibility and scope of services provided under Medicaid for Pregnant Women and Children.
- In comparison to the United States average, Idaho has been successful in reaching its population in need of Title X services. In the United States, approximately 40 percent of the women in need of public services received them, while Idaho served 50 percent of the target population. There were variations in planned pregnancies among age and ethnicity.
- Data strongly suggest that racial and ethnic discrepancies exist in Idaho in terms of diagnosing breast cancers early among younger women (aged less than approximately 55).
- There are a substantial number of women who report feeling depressed or have symptoms of depression but are not being diagnosed or treated. Those that have been diagnosed are being treated by their family physician.
- Two-thirds of pregnant women did not have dental care during their pregnancy, nor do they report being told by their prenatal providers about the importance of getting regular dental care.
- In Idaho, death rates due to diabetes based on a 3- year average (2000-2002) were twice as high for Hispanics compared to non-Hispanics and for non-Whites compared to Whites. Diabetes has reached epidemic proportions among Native Americans.

#### Analysis

- The continuum of mental health services is severely lacking. Screening at the physician's office is variable, there are few services that women are using that promote their emotional well-being, and there is a shortage of mental health professionals.
- Lack of affordable and quality health coverage is creating difficulties in accessing care.
- There are many potential opportunities through initiatives like Any-Door and the CareLine that, when optimized, could make a big difference in family's lives.

## **Pregnant women use early and adequate prenatal care.**

### **Summary**

- The percent of Idaho births where prenatal care was initiated in the first trimester was comparable to the national average. This overall comparison masks the differences by race, ethnicity, age, and region. The rate for the non-Hispanic White population in Idaho is slightly lower than the rate for the non-Hispanic White population in the United States.
- Data suggest that women did not receive services as early as they desired because they were unaware of the pregnancy, were not able to receive an appointment earlier, lacked money or insurance, did not have a Medicaid card, or found that the doctor would not start care earlier.
- All hospital and prenatal staff key informants indicated that they screen for medically high-risk pregnancies and, for those identified, try to arrange delivery in a hospital with a neonatal intensive care unit. There is no apparent statewide system of transfer or referrals.

### **Analysis**

- There is no universal or systematic high-risk prenatal identification system. Providers are not given training or guidelines; therefore, screening may vary by site and/or provider.
- Midwifery care is variable, and most midwives do not have strong ties to the medical community. Both of these issues raise the risk of inappropriate care for high-risk pregnancies.
- There is no systematic approach that provides comprehensive and coordinated health and enabling services based on a particular pregnant woman's need.
- While some providers respect, and are sensitive to a woman's culture and language and recognize the context and complexity of women's lives, there is evidence that some providers do not.

## **Pregnant women use as appropriate the full range of enabling and support services to promote a positive pregnancy outcome.**

### **Summary**

- Few mental health and other psychosocial services in Idaho appear to specifically target pregnant women and new mothers.
- Focus group participants indicated variable access to classes and support groups.
- WIC is very successful in reaching and serving pregnant women.

### **Analysis**

- There is not a system in place that screens women for psychosocial and environmental risk factors during and after pregnancy and refers them to appropriate services.
- Prenatal and parenting classes and parenting support groups are not available are not equally integrated into local resources in all communities. There is an opportunity to offer these classes and groups through local hospitals and community-based programs like WIC.

# MOTHERS

## Introduction

Much of what constitutes ongoing primary care has been touched on in the previous section. Women should receive regular breast and cervical cancer screening, have access to and utilize family planning and dental care, and take care of themselves by eating healthy and exercising regularly. Moreover, they should have access to the critical services necessary to prevent and treat violence in the home, substance abuse, and mental health issues.

This section of the report contains a closer look at postpartum care. Women and newborns must stay in the hospital for a sufficient amount of time to ensure the stable health status of both of them. Followup care for the mother should normally include a physician visit at 6 weeks postpartum. During that visit a medical exam should be conducted as well as screening for postpartum depression and discussion of and services for family planning goals. The visit and followup care should assess how the mother is adapting to parenting by observing parent-infant attachment and whether she has developmentally appropriate expectations.

## Characteristics of Mothers

- **Marital Status.** Because the marital status of a mother can affect her economic well-being and ability to meet the full range of needs of her infant, it is useful to review this data. While the number of Idaho resident out-of-wedlock births has increased each year since 1998, the percent of total live births that were out-of-wedlock births decreased slightly from 22.0 in 2001 to 21.9 in 2002 (IDHW, 2004). It is important to note that Idaho has a predominately White population and therefore the actual numbers of these births to other racial and ethnic groups is relatively small.

<b>Table V-19.</b>			
<b>Idaho Out-of-wedlock Births by Race and Ethnicity</b>			
	<b>2002</b>	<b>2001</b>	<b>2000</b>
Total	21.9%	22.0%	21.6%
White	21.2	21.4	20.9
Black	33.0	40.5	46.7
Am. Indian	54.0	56.9	60.0
Asian/Pacific Islander	13.8	11.6	15.9
Ethnicity: Hispanic*	36.1	34.1	33.1

\*Race and Hispanic origin are reported separately on the birth certificate. Women of Hispanic origin are included in appropriate race totals.

Source: IDHW, 2000, 2001, 2004a

- **Maternal Age.** Between 1991 and 2003, the U.S. birth rate for teens aged 15-19 declined to 43.0 births per 1,000 teen girls in 2002, after reaching its highest point in two decades (61.8 births per 1,000 teen girls aged 15-19 in 1991). Idaho ranks

24<sup>th</sup> among the States with a 2002 teen birth rate of 39.1 (National Campaign to Prevent Teen Pregnancy, 2004). The following table displays the teen births by race or ethnicity and by age of mother for the average of years 2001-2003.

<b>Table V-20.</b>								
<b>Idaho Resident Teen Live Births</b>								
<b>Number and Rate of Live Births by Race, Ethnicity, and Age, 2001-2003</b>								
RACE / ETHNICITY	AGE							
	<15		15-19		15-17		18-19	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
<b>U.S. Total</b>	<b>0.7</b>		<b>43.0</b>		<b>23.2</b>		<b>72.8</b>	
Idaho Total	56	0.4	6,362	39.8	1,731	18.3	4,631	71.2
Race								
White	52	0.4	5,955	38.9	1,616	17.8	4,339	69.7
Black	-	-	40	33.2	11	17.9	29	49.1
American Indian	2	0.6	200	63.4	60	31.7	140	110.8
Asian or Pacific Islander	-	-	66	29.5	15	11.2	51	56.9
Other Race	-	N/A	3	N/A	1	N/A	2	N/A
Race Not Stated	2	N/A	98	N/A	28	N/A	70	N/A
Ethnicity								
Hispanic	29	1.6	1,503	93.7	552	58.2	951	144.7

Teen Birth Rate: Number of births in specified age group per 1,000 females in corresponding age group (based on July 1, 2002 bridged race population estimates released August 8, 2003).  
Source: IDHW, 2004c.

Births to White teens were recorded at 38.9 (6,362 births) in average of 2001-2003, with births to Hispanic teens at 93.7 (1,503 births) and to American Indian teens at 63.4. Information about teen birth rates is important as these young women may be at risk for a number of health and social problems and often need extra support in caring for an infant.

- ***Mother's Level of Education.*** Also of interest is the mother's level of education, because of its association with pregnancy outcomes.

Approximately half of Idaho births were to mothers with some college education or higher (49 percent). Only 15 percent of Idaho mothers had less than a high-school degree; however, there was wide variation among districts, with 27 percent in District 5 and 10 percent in District 4 (IDHW, 2004a). In Idaho, low educational attainment is linked to unintended pregnancy, risk of physical abuse, smoking during pregnancy, and breastfeeding rates (IDHW, 2005a).

<b>Table V-21.</b> <b>Percent of Idaho Births by Mother's Education, 2002</b>						
		<b>&lt;High School</b>	<b>High-School Graduate</b>	<b>Some College</b>	<b>Bachelor's Degree or Higher</b>	<b>Not Stated</b>
<b>Idaho</b>	<b>20,973</b>	<b>15%</b>	<b>32%</b>	<b>29%</b>	<b>20%</b>	<b>3%</b>
District 1	2,226	12%	40%	27%	18%	3%
District 2	1,189	11%	31%	30%	28%	0%
District 3	3,715	22%	34%	23%	13%	8%
District 4	5,563	10%	27%	30%	30%	3%
District 5	2,550	27%	29%	26%	15%	3%
District 6	2,789	13%	40%	28%	17%	2%
District 7	2,941	13%	29%	43%	15%	1%

Source: IDHW, 2004a

Given this demographic context, the rest of the chapter explores mothers' access to postpartum health and enabling services and breastfeeding rates.

### **Idaho Health Outcomes for Mothers**

Three outcomes have been selected for in-depth examination for the Idaho maternal population. Achieving these outcomes will help to ensure that women and the families they care for are healthy.

<b>Table V-22.</b> <b>Idaho Mothers Outcomes</b>
Mothers use comprehensive postpartum services and ongoing primary care.
Mothers use as appropriate the enabling and support services needed by them and their families to care for their infants and children.
Mothers have access to breastfeeding information and support as needed.

#### **1. *Mothers use comprehensive postpartum services and ongoing primary care.***

The American Academy of Pediatrics has recommended specific criteria for newborn discharge; and in most instances, it is unlikely that fulfillment of these criteria and conditions can be accomplished in less than 48 hours (AAP, 2004). If discharge is considered before 48 hours, it should be limited to infants who are of singleton birth between 38 and 42 weeks' gestation, who are of birth weight appropriate for gestational age, and who meet other specific discharge criteria. Given that hospital-specific discharge data is not analyzed by the State, nor are there State-level protocol or regulations on hospital stay, hospital policies and procedures and whether those procedures are being followed are unknown. It is also unknown whether some hospitals are discharging patients earlier than other hospitals.

The American Academy of Pediatrics and American College of Obstetrics and Gynecology recommend that, prior to discharge, the mother be informed of normal postpartum events,



including the changes in the lochial pattern that she should expect in the first few weeks; the range of activities that she may reasonably undertake; the care of the breasts, perineum, and bladder; dietary needs, particularly if she is breastfeeding; the recommended amount of exercise; emotional responses; and observations that she should report to the physician (e.g., temperature elevation, chills, leg pains, or increased vaginal bleeding).

According to self-reported 2001 PRATS data, 75 percent of Idaho resident adult mothers spent less than 48 hours in the hospital or birthing center after childbirth. Fifty-nine (59) percent spent one to two days, while 16 percent spent less than 24 hours. Similarly, most babies (55.6 percent) spent 1-2 days in the hospital or birthing center after birth. More babies spent 4 or more days in the hospital or birthing center (12.9 percent) than mothers (8.4 percent) (IDHW, 2005a).

Most focus group participants stated that they received no information from the hospital about what to expect after delivery. Those that did receive information stated it was through brochures given by the hospital. Two mothers received special training, such as baby CPR, which they found very useful. The same mothers received follow up telephone calls from providers.

Generally, Hispanic focus group participants recounted tales of bad experiences during delivery:

- One woman described how she went to the hospital in labor and her physician asked her to go home and return later when she was closer to delivery. Instead, she ended up giving birth shortly thereafter and he sent her home the same day.
- Another woman reported that a friend of hers was also sent home the same day as delivery.
- Another woman was told she would have to wait until the next scheduled meal before receiving food and water after her delivery.
- Another woman was not given an epidural even though she asked for one 6 hours in advance of delivery.

All Hispanic participants agreed that deliveries tended to go smoother if patients were fluent in English.

After delivery, only two focus group participants received a home visit, one from the Prenatal Ancillary Care (PAC) Program for low-income mothers and one from the Infant-Toddler Program. Both mothers were very satisfied with the timeliness and usefulness of the home visit. Many other mothers noted they would have liked to receive a home visit, particularly for those who had perinatal or birth complications. Some even specifically requested breastfeeding education from the birth hospital but did not receive it. Fortunately, both Hispanic and non-Hispanic mothers seemed to have a more positive experience in WIC, receiving both breastfeeding support and information about caring for their infant.

Little information is available to assess the number of women receiving postpartum care and the quality of that care. One recent study surveyed Idaho hospitals and learned that 9 out of the 35

had existing programs or were developing postpartum depression support groups (IDHW, 2005c).

There were no reported maternal deaths in 2001 or 2002. In 2000, two deaths were reported, but their causes were not reported. The State does not regularly assess or report maternal illness and complications due to pregnancy.

**2. *Mothers use as appropriate the enabling and support services needed by them and their families to care for their infants and children.***

As described earlier, many parents rely on WIC for nutritional education and support. Some focus group participants in this needs assessment reported that WIC will also hold classes on the days mothers come in to receive their food vouchers. The Idaho Department of Health and Welfare has developed a series of informational brochures for women in the perinatal period. The brochure *After You Deliver: Health Tips for Moms* includes information on nutrition, breastfeeding, and immunizations. There are also brochures on perinatal substance abuse, SIDS, WIC, and benefits of folic acid, among other topics.

Families also should have access to health and parenting education. Such education could include recognizing signs of stress and learning appropriate coping mechanisms; developing appropriate expectations; and supporting healthy communication skills and healthy relationships, including decisionmaking, negotiation skills, and parenting discipline. Parenting support is explored further in the Infant section of this report.

Focus group participants described receiving services through the Family Service Alliance, which offers help to victims of domestic violence and other at-risk parents and PAT. Only one participant received home visits through PAT; generally, participants felt that there were not enough parenting classes available for the general community. They expressed a desire for parent support groups, especially for first-time mothers and parents of CSHCN.

**3. *Mothers have access to breastfeeding information and support as needed.***

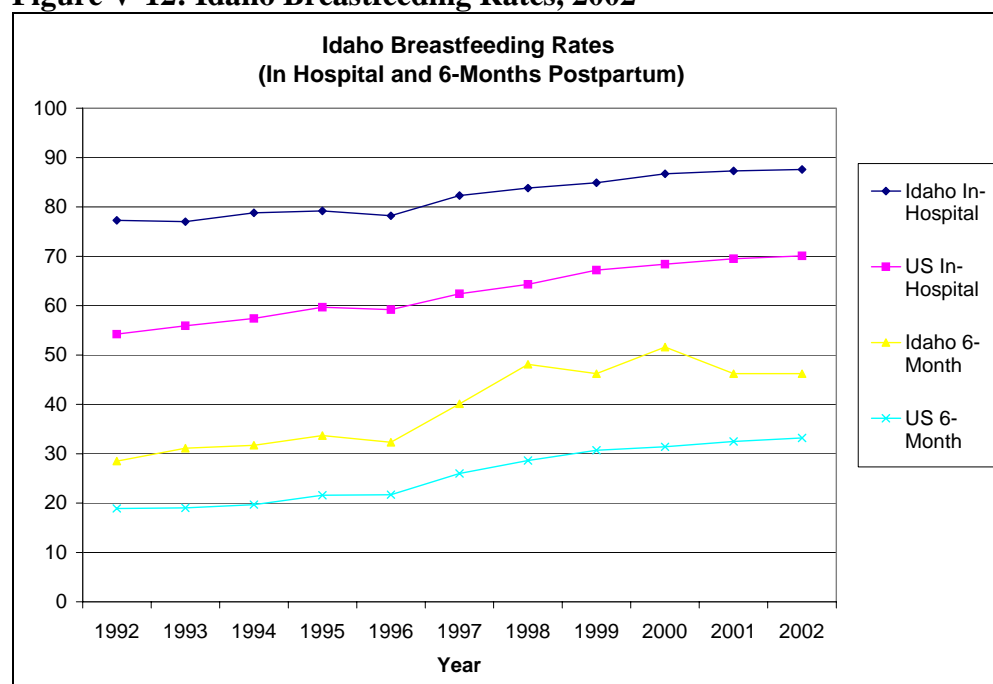
**Breastfeeding Initiation and Duration**

New breastfeeding data collected as part of CDC's 2003 National Immunization Survey (NIS), indicated that only six states, including Idaho, met all of the Healthy People 2010 objectives for breastfeeding. Across these six states, 75 percent of mothers initiated breastfeeding in the hospital and 50 percent maintained breastfeeding at 6 months postpartum (National Immunization Program, 2003).

The Ross Mothers Survey (an ongoing mail survey periodically sent to a nationally representative sample of new mothers), provides data specifically for Idaho. According to the 2002 Survey, the proportion of Idaho mothers initiating breastfeeding has been nearly 20 percent higher than the national average and the proportion continuing breastfeeding at 6 months post partum has been nearly 10 percent higher (Figure V-12). In fact, 87.6 percent of Idaho mothers

initiated breastfeeding at the hospital and 46.2 percent were breastfeeding at 6 months postpartum, meeting the 2010 goals for initiation and almost meeting the goal for duration in 2002 (Ross Products Division, 2003).

**Figure V-12: Idaho Breastfeeding Rates, 2002**



Source: Ross Products Division, 2003

Assessing the percent of women who only fed their infant breastmilk and water—no solids or other liquids—describes a somewhat different story. While Idaho was still much higher than the national average, in 2002, 55.7 percent ( $\pm 6.0$  percent) of women reported exclusively breastfeeding at 3 months and 23.9 percent ( $\pm 5.3$  percent) at 6 months (National Immunization Program, 2003).

Idaho WIC participants are also more likely to breastfeed than WIC participants at the national level. In 2002, Ross data indicated that 83.7 percent of Idaho WIC participants initiated breastfeeding in comparison to 58.2 percent nationwide. Similarly, 35.5 percent of Idaho WIC participants were breastfeeding at 6 months postpartum, compared to 20.8 percent nationwide.

Data from the Idaho WIC program in 2001 indicates similar rates; and with program data, we are also able to look at regional variation. The South Central region reported the lowest initiation rates at 70 percent, and North Central was the highest at 85 percent. Interestingly, the North Central region experienced the largest decrease, with only 25 percent breastfeeding at 6 months.

<b>Table V-23.</b>							
	<b>Initiation</b>	<b>One Month</b>	<b>Two Months</b>	<b>Three Months</b>	<b>Four Months</b>	<b>Five Months</b>	<b>Six Months</b>
<b>Statewide</b>	<b>79</b>	<b>66</b>	<b>51</b>	<b>44</b>	<b>39</b>	<b>36</b>	<b>32</b>
Panhandle	80	68	55	45	43	40	36
North Central	85	69	51	43	36	32	25
Southwest	78	63	50	47	41	36	33
Central	81	68	52	47	41	40	38
South Central	70	58	45	37	30	28	24
Southeastern	76	64	51	45	38	34	31
District 7	83	71	53	44	44	40	34

Source: Idaho WIC Program, 2002

In 2001, PRATS data indicates an even higher breastfeeding rate than the Ross data, with 89.2 percent of Idaho adult mothers reporting they ever breastfed their baby. Women were more likely to initiate breastfeeding if they had high educational attainment for age, high household income, or were married. Women were also more likely to initiate breastfeeding with their first child, but women with more than 1 child were slightly more likely to continue breastfeeding at 6 months postpartum. While maternal employment had little impact on breastfeeding initiation, women who were employed full time are less likely to breastfeed 6 months after the birth of their child than women who were not employed or working part time (IDHW, 2005a).

A variety of reasons for discontinuing breastfeeding were given by PRATS respondents. The most common were not having enough milk (32.5 percent) and breast milk alone not satisfying their baby (29.1 percent). Other reasons include nipple or breast problems (13.3 percent), inconvenience to continue (13.0 percent), and needing someone else to feed the baby (10.1 percent), among others (IDHW, 2005a).

- ***Access to Lactation Support Services***

Lactation support services, for the most part, are available through WIC, La Leche, and hospital classes.

Focus group participants indicated they had access to lactation specialists who were very helpful, many of whom were available on call. One issue reported was that most insurers do not cover breastfeeding pump costs. One provider whose patients often receive services across the border in Washington described how she regularly uses the Washington Healthy Mothers Healthy Babies Web site for breastfeeding resources and support. She suggested that the Idaho Department of Health create a similar accessible and useful site.

## **Idaho Health Outcomes for Mothers**

### **Mothers use comprehensive postpartum services and ongoing primary care.**

#### **Summary**

- Data is not available to examine whether women obtain postpartum visits.
- Seventy-five (75) percent of Idaho resident adult mothers spent less than 48 hours in the hospital or birthing center after childbirth. Fifty-nine (59) percent spent 1-2 days, while 16 percent spent less than 24 hours.
- Women want information on what to expect, breastfeeding support, and parenting issues, and many are unable to access them.
- No system is in place that identifies pregnancy-related morbidity and mortality trends and responds accordingly.

#### **Analysis**

- There is a need for data on the use of postpartum care
- There is a need to emphasize the value of postpartum care and its ability to link women to needed community and preventive services.

### **Mothers use as appropriate the enabling and support services needed by them and their families to care for their infants and children.**

#### **Summary**

See Infant Section

#### **Analysis**

### **Mothers have access to breastfeeding information and support as needed.**

#### **Summary**

- The percentage of Idaho mothers initiating and continuing at 6 months postpartum is higher than the national average. In 2002, 87.6 percent of Idaho mothers initiated breastfeeding at the hospital, and 46.2 percent were breastfeeding at 6 months postpartum, meeting the 2010 goals for initiation and almost meeting the goal for duration.
- Idaho WIC participants are also more likely to breastfeed than WIC participants at the national level.
- Most health insurance companies do not cover breast pumps.

#### **Analysis**

- While breastfeeding rates are high, reasons given for not continuing could be addressed with additional lactation support.

## CHAPTER VI

### Infants

---

In 2002, 20,970 infants were born in Idaho (Idaho Department of Health and Welfare, 2004a) with their families and health care providers hopeful that each infant would arrive at term, of normal weight, without preventable defects and subsequently screened for potential problems. The first year of the infant's life is a time of rapid growth and development, and what happens during this period matters a great deal because it sets either a sturdy or a fragile stage for what follows in the life of the child and future adult (National Research Council and Institute of Medicine, 2000).

This section of the assessment describes the health and well-being of Idaho's infants from birth to 1 year of age.

#### A. Characteristics of Births in Idaho

The birth rate (total number of births per 100,000 people based on 2004 population estimates) for the entire State was 15.8 in 2002 and increased to 16 in 2003 with 21,802 births reported in the State. In comparison, the U.S. birth rate was reported as 13.9 for 2002 and as 14.1 for 2003. Despite a nationwide decline in the number of births over the past decade, a number of States, including Idaho, are showing significant increases (National Center for Health Statistics, Trends in Characteristics of Births by State, 2004). Idaho is also reporting changes in the race and ethnicity distribution of infants born in the State, as displayed in Table VI-1.

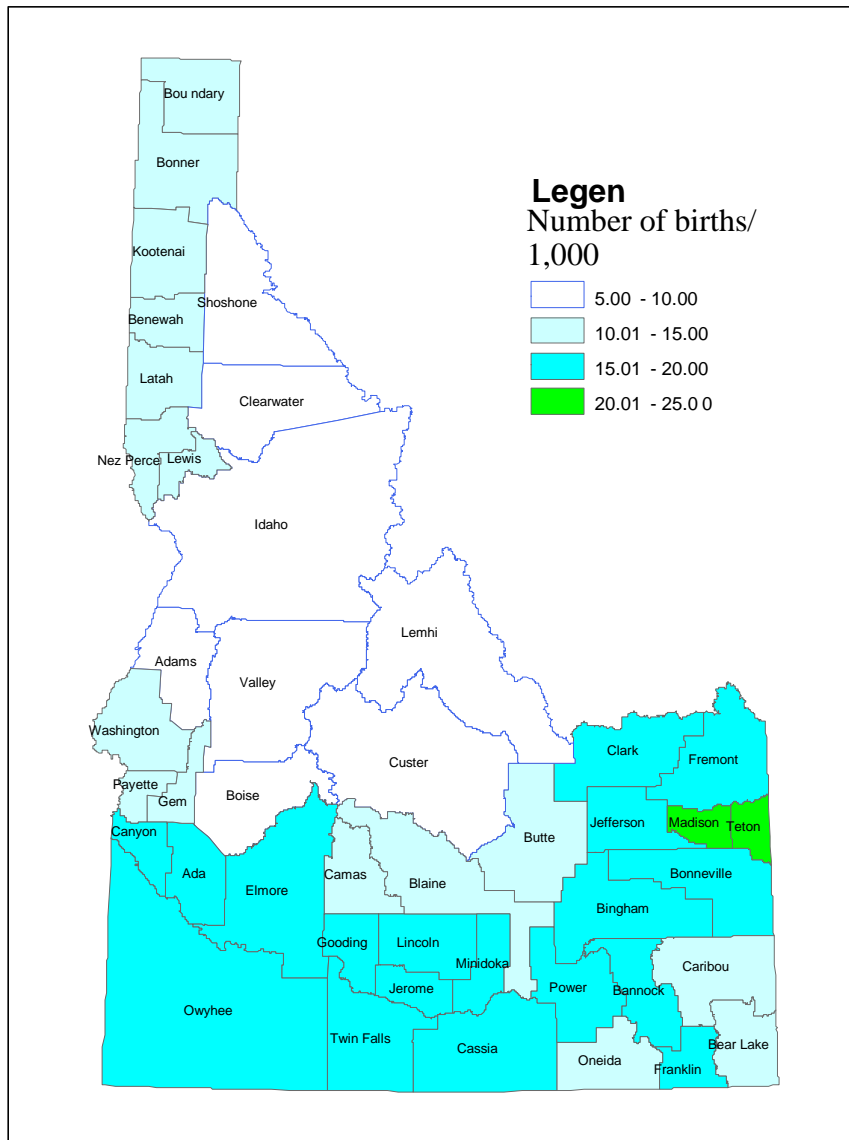
<b>Table VI-1. Idaho Resident Live Births by Race and Ethnicity, 2000-2002</b>						
	Idaho Total	Non- Hispanic White	American Indian	Asian Pacific	Non- Hispanic Black	Hispanic
2002	20,970	17,074 (81.4%)	377 (1.8%)	339 (1.6%)	100 (.5%)	2,788 (13.3%)
2001	20,688	16,855 (81.5%)	360 (1.7%)	298 (1.4%)	78 (.4%)	2,753 (13.3%)
2000	20,336	17,021 (83.7%)	288 (1.4%)	298 (1.4%)	74 (.4%)	2,599 (12.8%)

Source: Sutton and Mathews, 2004

The southern part of the State is reporting the most births in the State and this is reflective of the growing population residing in this area.

Birth rates by county are displayed in Figure VI-1:

### Live Birth Rates (2001 -2003)



**Figure VI-1: Live Birth Rates, 2001-2003**

Source: Idaho Department of Health and Welfare, 2004b

Counties reporting the highest birth rates include Madison with 20.8, Teton with 20.4, Canyon with 19.7, and Jefferson with 18.1. Of the 63,453 live births between 2000 and 2002, 8,478 or 13.4 percent of all births were reported as Hispanic. Counties with the highest Hispanic birth rates include Valley with 38.8, Camas with 35.3, Bear Lake with 35.3, Blaine with 31.7, Lincoln

with 30.3, and Payette with 30 (Idaho Department of Health and Welfare, September 2004). A significant percentage of Idaho births are occurring to mothers of Hispanic origin requiring the perinatal health system to be sensitive to the special needs and concern of this population in terms of language, culture, and health-seeking behaviors.

## Characteristics of Birthplace

- *Site of Births and Birth Attendant*

The majority of births occurred in a hospital setting and were attended by a physician (19,774), others by a certified nurse-midwife (782), and still others by a lay midwife (272). In addition, 50 births were attended by a naturopath and 42 by a nurse. In 2002, 34.2 percent of total live births were financed by Medicaid (Kaiser State Health Facts, 2000).

<b>Table VI-2. Infants Place of Birth in Idaho - 2002</b>		
<b>Place of Birth</b>	<b>Number</b>	<b>Percent of Total Births</b>
Hospital	20,470	97.6
Freestanding Birthing Center	145	0.7
Clinic/Doctor's Office	1	0.0
Home	351	1.7
Other	2	0.0
Not reported	4	0.0
<b>Total Births</b>	<b>20, 973</b>	<b>100%</b>

Source: Idaho Department of Health and Welfare, 2004a

While most Idaho infants are delivered in a hospital, Idaho does report a higher rate of home births, 1.7, than the national rate of 0.6 (Martin et al., 2003). While the number of births attended by a midwife is relatively small in Idaho, key-informant interviewees and women participating in the focus groups indicated that women are interested in having birthing site and attendant options available to them.

The State nurse-practice act was changed in 1998 to permit the practice of nurse-midwifery in Idaho. There are five CNM practice sites in Idaho authorized for delivery services. These are located in Coeur d'Alene, Boise, Jerome, Rexburg, and Pocatello. Although CNMs may legally conduct a home delivery within a circumscribed protocol and with appropriate physician backup, none do so in Idaho.

Another classification of midwife, called direct-entry midwives, also practices in Idaho. Non-nurse-midwives practicing in Idaho may be certified by the North American Registry of Midwives (NARM). Midwives need documentation of compliance with practice requirements and the successful completion of an examination. This permits these midwives to identify themselves as certified professional midwives (CPMs). While these midwives are licensed in several States, they are not licensed in Idaho.



A total of 496 births or 2.4 percent of total births occur outside the hospital, necessitating the need for a system that ensures that the infants are appropriately screened for metabolic conditions and hearing loss and have access to a medical home.

<b>Table VI-3. Number of Out-of-hospital Births, 2002</b>			
	<b>Freestanding Birthing Center</b>	<b>Home Birth</b>	<b>Percent of Out- of-hospital Births by District</b>
District I	2	91	4
District II	1	49	4
District III	114	81	5.2
District IV	27	52	1.4
District V	-	34	1.3
District VI	-	17	.6
District VII	1	27	.9
Total	145	351	2.4

Source: IDHW Bureau of Health Policy and Vital Statistics, 2004a

- Method of Delivery.** Overall, Idaho ranks lower than most other States for rates of births by cesarean delivery, with a 2002 rate of 19.7 and a 2003 rate of 21.2 compared to national rates of 26.1 and 27.6, respectively. A somewhat higher rate is reported for Hispanic mothers, with a 2002 rate of 20.5 and 2003 rate of 21.6 (Hamilton et al., 2004). The March of Dimes (2004a) reports that in Idaho in 2002, the rate of primary cesarean deliveries was 12.8 per 100 live births to women who have not had a previous cesarean delivery. The rate of vaginal births after a previous cesarean was 17.4 per 100 live births to women who have had a previous cesarean delivery compared with a U.S. rate of 12.6 (March of Dimes, 2004b).

## Summary

Idaho reported 20,970 births in 2002 and experienced a higher birth rate (15.8) than the national rate of 13.9, with the birthrate continuing to grow in 2003. Most of the births were to White mothers, with a number of mothers indicating Hispanic ethnicity. Several counties reported birth rates above the statewide average; these included Madison, Teton, Canyon, and Jefferson. Counties, with high rates of birth to Hispanic mothers included Valley, Camas, Bear Lake, and Blaine. A high percentage of births were to American Indian, Black, and Hispanic mothers who were unmarried. Idaho ranks 28<sup>th</sup> among the States with a 2002 teen birth rate of 39.1. Higher teen birth rates were reported for American Indian, Black, and Hispanic mothers.

Although most births in Idaho occur in a hospital setting, the State does report a higher rate of home births than the national rate. A number of births in the State were attended by midwives. Idaho ranks in the 10 lowest for rates of birth by cesarean section delivery.

We now have a picture of the resident live births in Idaho that includes the number of births and birth rates. Within the context of these findings, the discussion now turns to a review of birth outcomes. Data is presented for each outcome along with information about current programs and services related to the outcome.

## B. Infant Outcomes Examined

Four outcomes have been selected for indepth examination of the Idaho infant population. Achieving these outcomes will help to ensure that infants have the best start in life enabling them to reach their full potential and that their families are provided the support they to help their infants grow and develop appropriately.

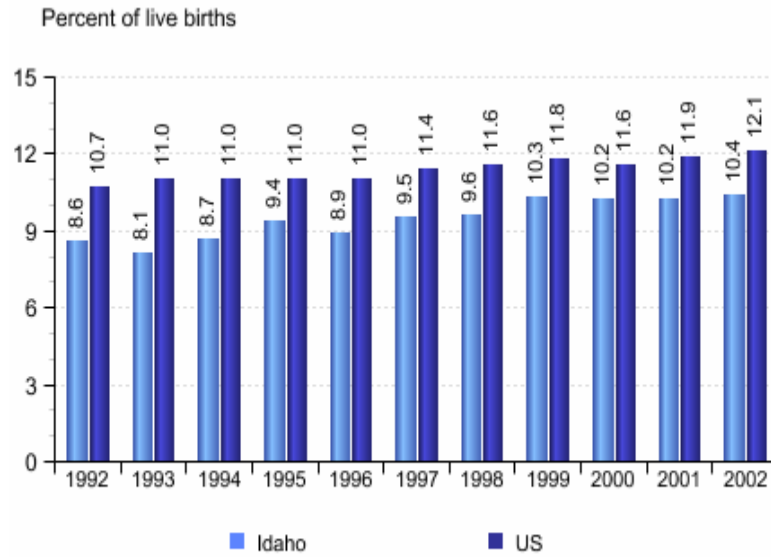
<b>Table VI-5. Idaho Infant Outcomes</b>
Infants are born at term, of normal weight, without preventable congenital defects and are appropriately screened for potential problems.
VLBW/preterm babies are born in facilities equipped to care for them.
Infants are welcomed into a family, a home, and a community that is prepared to care for them.
Infants appropriately receive ongoing comprehensive preventive and primary care.

### **1. *Infants are born at term, of normal weight, without preventable congenital defects and are appropriately screened for potential problems.***

Unfortunately, not all infants are born full term, at normal weight, and without preventable anomalies, and an increasing number of infants are born prematurely or at LBW. Classifying births by gestation and birth weight is useful because this characteristic often corresponds to clinical morbidities or illnesses that affect the health of the infants and their subsequent growth, development, and well-being.

While both premature and LBW births are described individually, it is useful to consider the parallel increase in the trends for both premature and LBW rates over time. Trends for preterm and LBW births by percent of live births for the years 1992 through 2002 are displayed in the following two graphs.

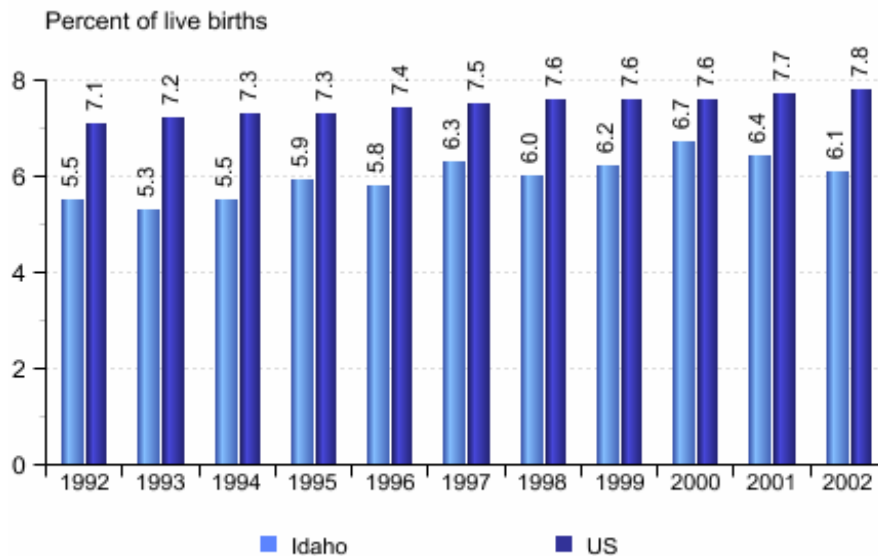
**Figure VI-2: Preterm Births: Idaho and U.S., 1992-2002**



Copyright March of Dimes, 2004

Note: Data is from the National Center for Health Statistics, final natality data.  
Source: March of Dimes, 2004c

**Figure VI-3: LBW Births: Idaho, 1992-2002**



Copyright March of Dimes, 2004

Note: Data is from the National Center for Health Statistics, final natality data.  
Source: March of Dimes, 2004d

Over this 10-year period, Idaho has consistently reported lower percentages of both preterm and LBW births than the U.S. percentages (Figure VI-3). However, the percentage of preterm live births in Idaho has fairly consistently increased over time, reaching 10.4 percent in 2002. It is important to note that the Healthy People 2010 goal for preterm births is to reduce to no more than 7.6 percent of live births and to reduce the LBW rate to no more than 5 percent of live births (U.S. Department of Health and Human Services, 2000). Idaho is coming much closer to the national goal for LBW births than for premature births (Figure VI-4).

LBW and premature births are both important public health problems due to the seriousness of acute complications and long-term consequences to the infant, the infant's family, and society as a whole. The March of Dimes (2005) reports that more than 60 percent of all infants born in the United States under 2,500 grams are also preterm. Compared with full-term LBW babies, preterm LBW infants are at greater risk of morbidity, mortality, and disability.

While the causes of LBW and preterm birth may be different in some cases and are not well-known, there is significant overlap within these populations of infants. Table VI-6 displays the Idaho live births by weight and gestational age for a 3-year period (2001-2003). Reviewing data over a period of 3 years provides a truer picture of outcomes than the review of a single year, in which some unusual events may produce an atypical picture of outcomes.

<b>Table VI-6.</b> <b>Idaho Resident Live Births by Weight and Gestational Age 2001 -2003</b>				
	Birth Weight			
<b>Total Idaho Births:</b> 63,453 (2001-2003)	< 1,500 Grams (VLBW)	1,500-2,499 Grams (LBW)	2,500-3,999 Grams (Normal Weight)	4,000-4,499 Grams (High Birth Weight)
	629 (1.0%)	3,408 (5.4%)	53,826 (84.9%)	4,764 (7.5%)
	<i>Gestational Age*</i>			
	< 32 Weeks (Very Preterm)	32-36 Weeks (Preterm)	37+ Weeks (Normal Term)	
	880 (1.4%)	5,675 (9.0%)	56,699 (89.6%)	
* Gestation is based on the interval between the date of the mother's last menstrual cycle (LMC) and the date of birth.				

Source: Idaho Department of Health and Welfare, 2004b

Further classification by race and ethnic group offers additional insights. Idaho rates for birth weight and preterm birth by race or ethnicity are displayed in Table VI-7. The table includes data for VLBW infants and very preterm infants as defined in Table VI-6.

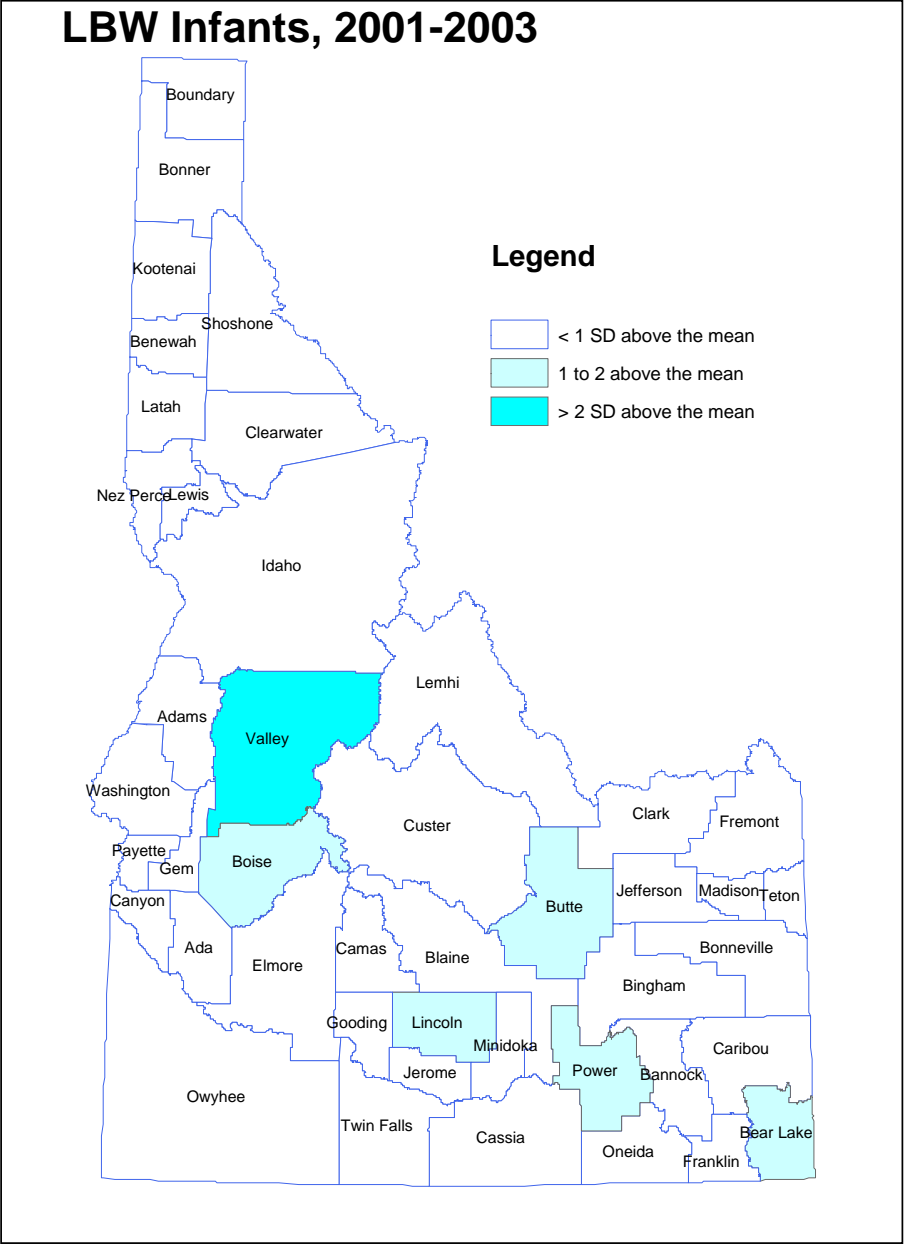
<b>Table VI-7. Birth Weight and Preterm Births by Race and Ethnicity, 2001-2003, by Percentage of Live Births for Idaho</b>						
<b>Population Groups:</b>	<b>All Races and Ethnicities</b>	<b>Am. Indian</b>	<b>Hispanic</b>	<b>Black</b>	<b>Asian</b>	<b>White</b>
<b>% Preterm Births:</b>						
Idaho	10.4	11.7	11.3	11.6	10.3	10.3
<b>% LBW*</b>						
Idaho	6.4	5.9	6.7	10.2	6.5	6.4

\*Less than 2,500 grams

Source: Idaho Department of Health and Welfare, 2004b

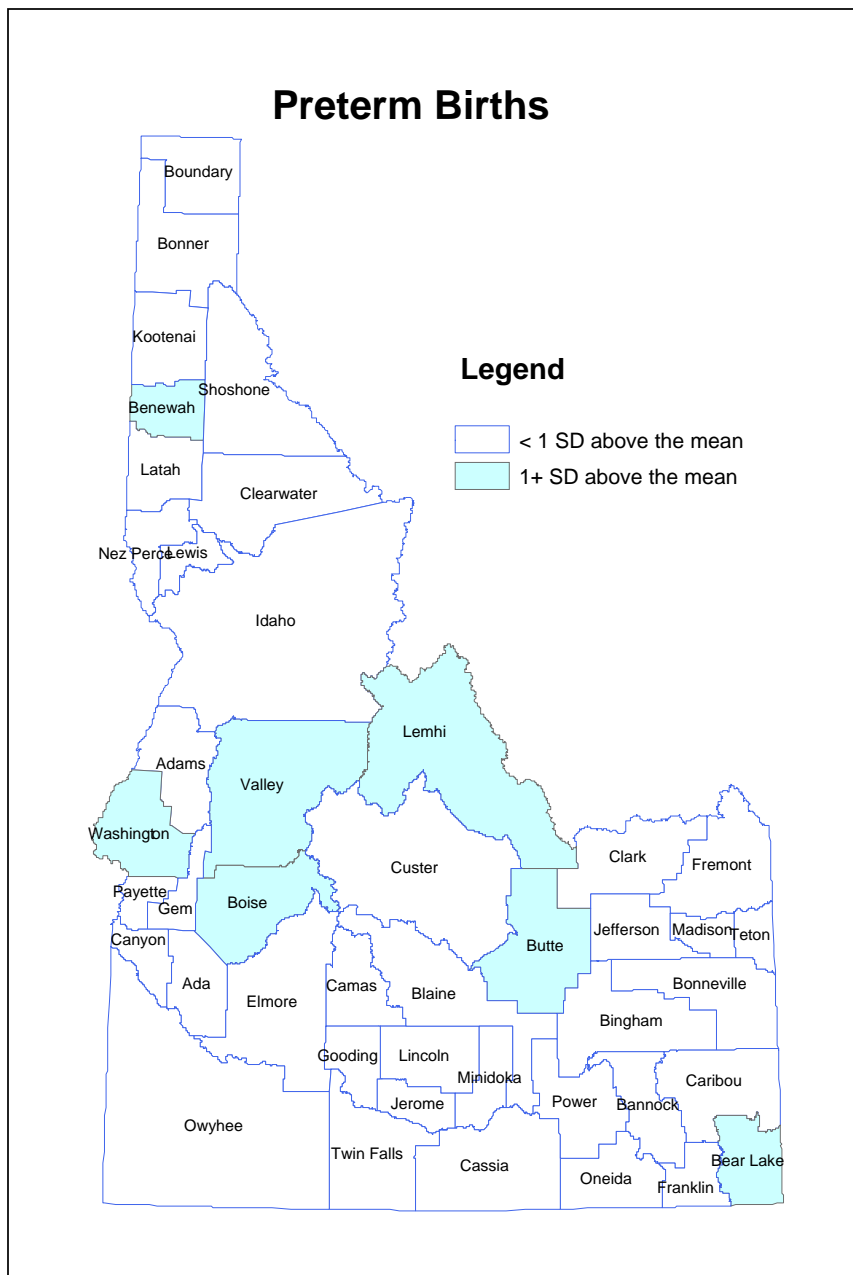
When the percentage of births in Idaho is reviewed by specific race and ethnicity, important differences are revealed, with a higher percentage of premature births reported for American Indian and Black infants.

It is also useful to review data at the county level. County-level data are displayed in a series of maps, presented here by a standardized measure of how much the county-level data differ from the mean (or average) of data from all counties. This standardized measure is known as the standard deviation. Therefore, counties with a very high rate of LBW births are identified as 2 plus standard deviations from the mean of the rates of LBW births for all counties. Counties with a high rate of LBWs have a standard deviation of 1-2 from the mean of the rates for all counties. Counties with low rates of LBW births are those with standard deviations of 1 or less from the mean of all counties. See Figure VI-4.



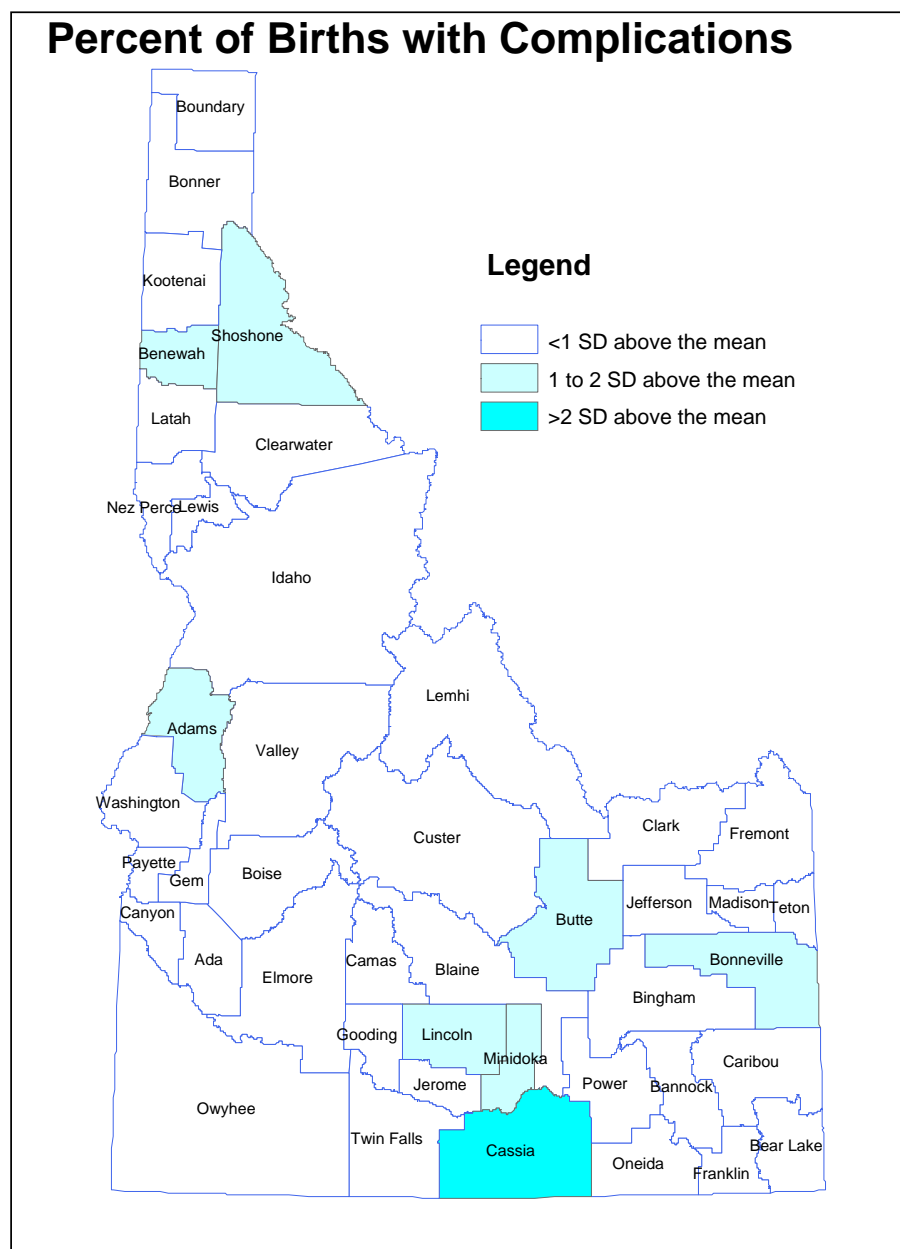
**Figure VI-4: Low Birth Weight Infants, 2001-2003**

Source: Idaho Department of Health and Welfare, 2004b



**Figure VI-5: Preterm Births, 2001-2003**  
 Source: Idaho Department of Health and Welfare, 2004b

Figure VI-6: Percent of Births with Complications (certain conditions originating in the perinatal period—ICD codes 760-779), 2001-2003 displays county-specific infant mortality data in the same fashion as the other maps.



**Figure VI-6: Percent of Births with Complications, 2001-2003**

Source: Idaho Department of Health and Welfare, 2004b



## Infant Deaths

Infant mortality is defined as death occurring during the first year of life. Infant deaths can be classified further into neonatal (0-27 days) and postneonatal (28-365 days) periods.

Neonatal mortality is typically associated with events surrounding the prenatal period and the delivery, whereas postneonatal deaths are more likely to be associated with conditions or events that arise after the delivery and may reflect environmental factors. Neonatal and postneonatal mortality are examined differently, as the primary prevention opportunities for each period differ in accordance with the period in which the death occurred. For example, VLBW-related deaths can be prevented best by addressing maternal health issues and by preventing and treating prematurity. Neonatal deaths can best be prevented by providing optimal newborn care and postneonatal deaths by improving infant care.

The following table displays the number and rate of infant deaths in Idaho for the year 2002 by neonatal and postneonatal periods by district.

<b>Table VI-8. Idaho Resident Infant Deaths 2002 Data</b>							
	<b>Total Live Births</b>	<b>Infant Deaths All Races and Ethnic Groups</b>					
		<b>Total</b>		<b>Neonatal</b>		<b>Postneonatal</b>	
		<b>Number</b>	<b>Rate</b>	<b>Number</b>	<b>Rate</b>	<b>Number</b>	<b>Rate</b>
Districts							
I	2,226	14	6.3	9	4.0	5	2.2
II	1,189	3	2.5	2	1.7	1	0.8
III	3,715	27	7.3	20	5.4	7	1.9
IV	5,563	35	6.3	24	4.3	11	2.0
V	2,550	17	6.7	8	3.1	9	3.5
VI	2,789	16	5.7	8	2.9	8	2.9
VII	2,941	15	5.1	13	4.4	2	0.7
<b>Idaho</b>	<b>20,973</b>	<b>127</b>	<b>6.1</b>	<b>84</b>	<b>4.0</b>	<b>43</b>	<b>2.1</b>

\*Per 1,000 deaths

Source: Idaho Department of Health and Welfare, 2004a

While Idaho reports virtually the same neonatal mortality rate as the United States as a whole, the death rate for non-Hispanic White infants is higher in Idaho than in the United States as a whole. The rate of deaths for infants in the neonatal period is significantly higher for Idaho's Hispanic neonates than the rate for the State as a whole or the U.S. Hispanic rate.

<b>Table VI-9. Neonatal Mortality Rates* of Non-Hispanic White and Hispanic Infants, Idaho and U.S., 2000-2002</b>		
	<b>U.S.</b>	<b>Idaho</b>
All Races	4.6	4.5
Non-Hispanic White	3.8	4.1
Hispanic**	3.8	6.8

\*Data are based on linked birth and death certificates for infants.

\*\* Infants of Hispanic origin could be any race.

Source: National Center for Health Statistics, 2004

Again, while overall Idaho rates seem to compare favorably with overall U.S. rates, when infant deaths are reviewed by specific race and ethnic groups, a very different picture emerges.

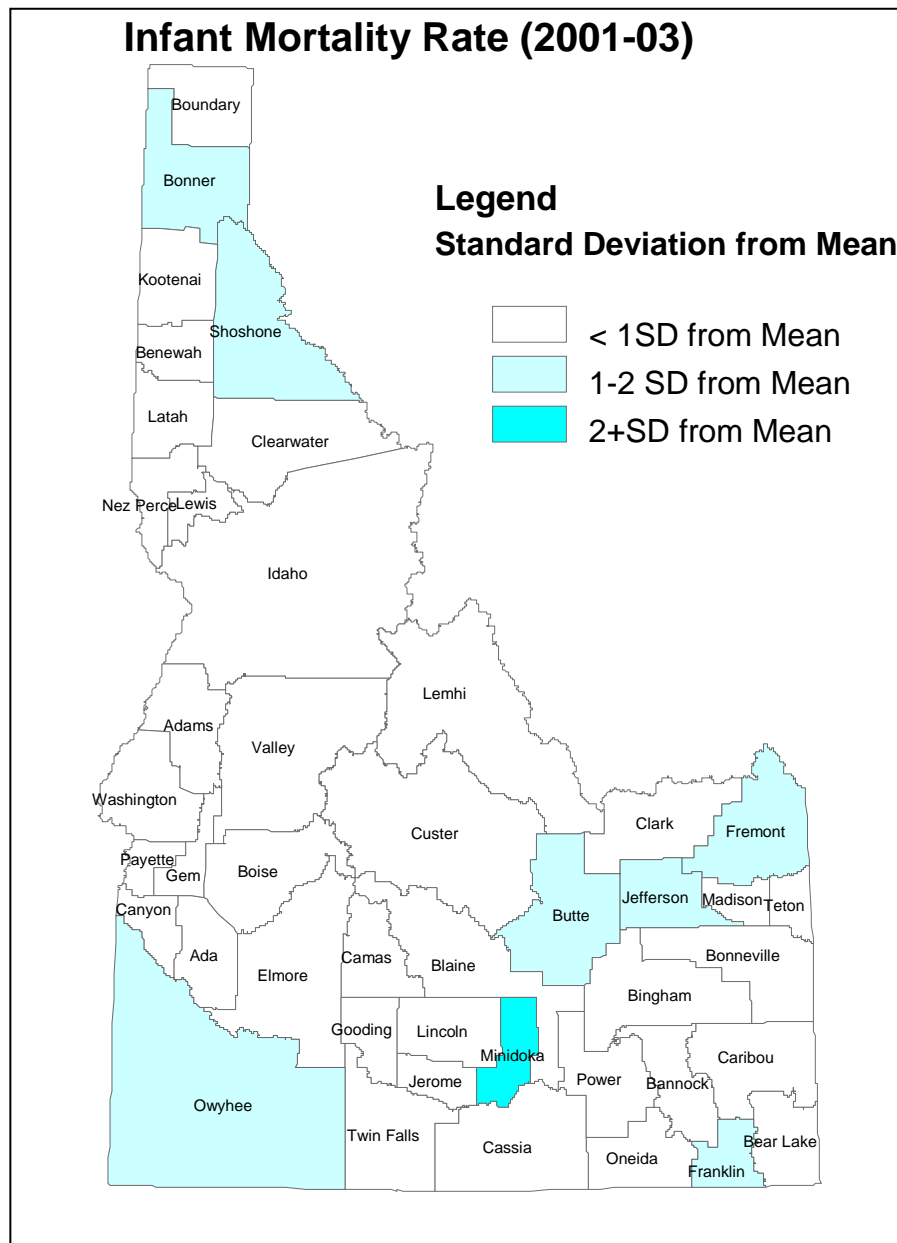
<b>Table VI-10. Infant Mortality Rates* of Non-Hispanic White and Hispanic Infants Idaho and US 2000-2002</b>		
	<b>US</b>	<b>Idaho</b>
All races	6.9	6.6
Non-Hispanic White Infants	5.7	6.2
Hispanic Infants**	5.5	8.8

\*Data are based on linked birth and death certificates for infants.

\*\* Infants of Hispanic origin can be of any race.

Source: National Center for Health Statistics, 2004

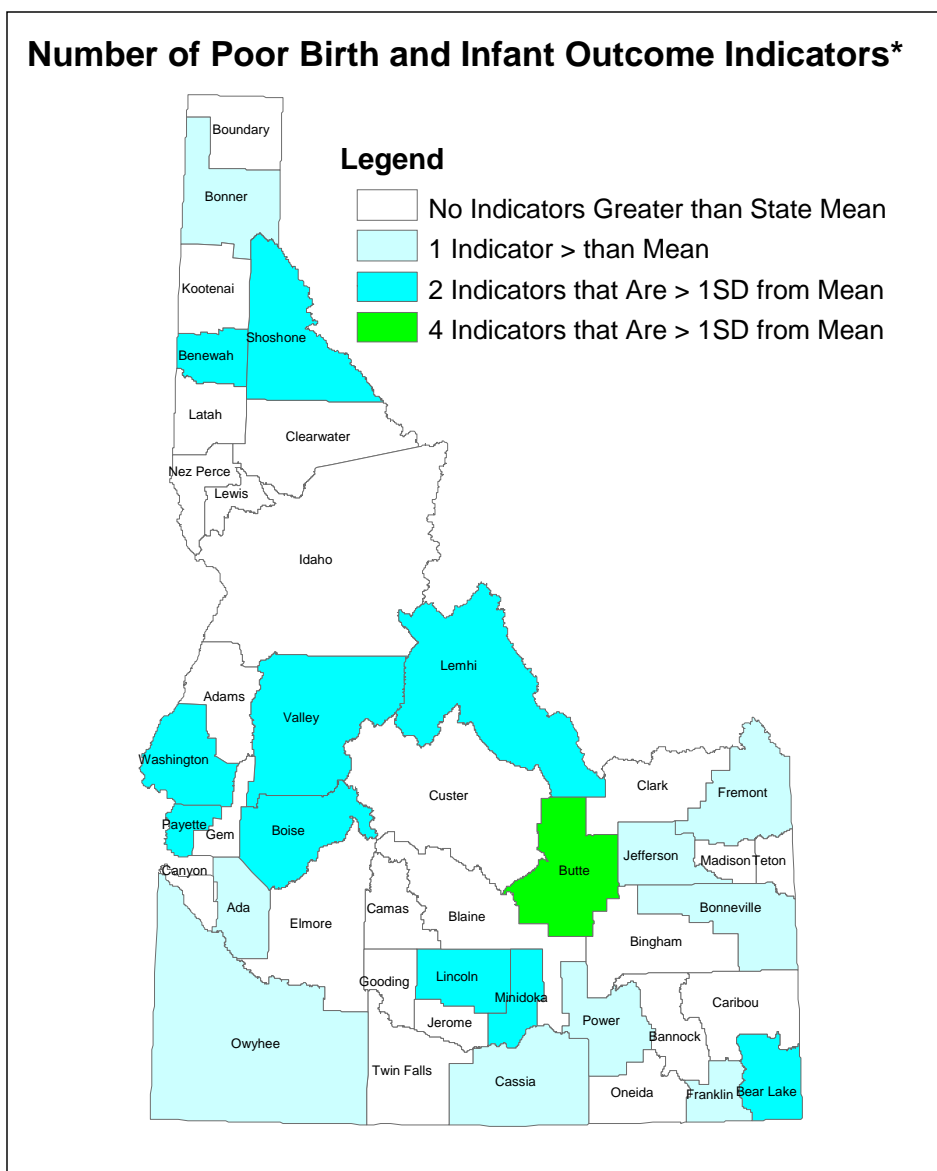
Overall, Idaho reports higher infant mortality rates for non-Hispanic White infants than the national rate and significantly higher rates for Hispanic infants.



**Figure VI-7: Infant Mortality Rate, 2001-2003**

Source: Idaho Department of Health and Welfare, 2004b

Finally, Figure VI-8: Number of Poor Birth Outcome Indicators per County displays counties by their number of poor birth outcome indicators. Indicators include the incidence of some degree higher than the State averages for infant mortality, premature and LBW births, and births with complications. Counties are identified with very high rates (4 indicators), high rates (2 indicators), and above average rates (1 indicator). None of the counties had 3 indicators.



**Figure VI-8: Number of Poor Birth and Infant Outcome Indicators**

\*ID Department of Health and Welfare Statistics. Indicators include high infant mortality rate per 1,000 (2001-03), high percentage of preterm births (2001-03), high percentage of LBW births (2001-03), and high percentage of live births with complications.

Source: Idaho Department of Health and Welfare, 2004b

As noted previously, counties with the highest Hispanic birth rates include Valley with 38.8, Camas with 35.3, Bear Lake with 35.3, Blaine with 31.7, Lincoln with 30.3, and Payette with 30 (Idaho Department of Health and Welfare, 2004a).

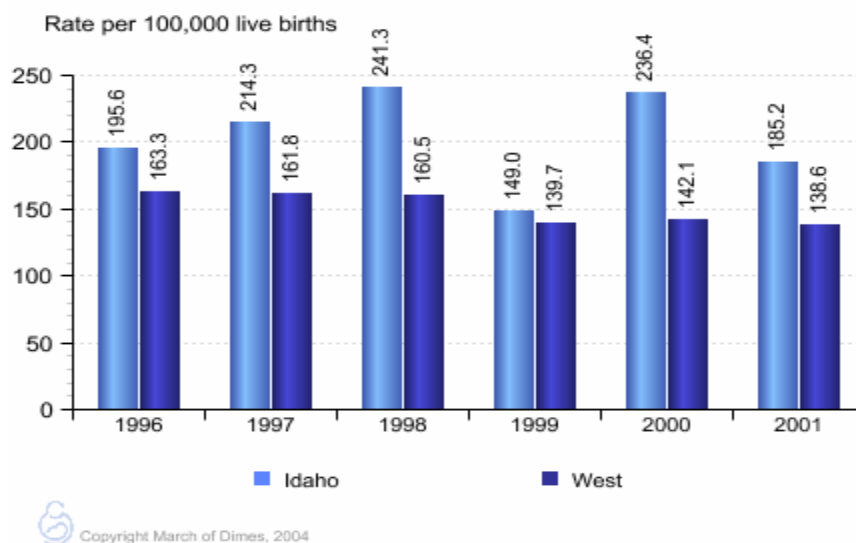
### What are the Causes of Death for Idaho Infants?

**Birth Defects/Congenital Anomalies.** A birth defect is an abnormality of structure, function, or body metabolism present at birth that results in physical or mental disability and may be fatal.

The general term “birth defect” may take on a variety of meanings depending on the context in which it is used. “Congenital abnormality,” “congenital anomaly,” and “congenital malformation” are terms often used as synonyms for “birth defect.” The term “congenital anomalies” is used in a revised ICD-10 code definition that includes a variety of congenital malformations, deformities, and abnormalities.

According to the IDHW Bureau of Health Policy and Vital Statistics, birth defects are the leading cause of infant mortality in the State, accounting for 1 of 3 or 30.7 percent of all infant deaths in Idaho in 2002 (Idaho Department of Health and Welfare, 2004a). According to the March of Dimes, the national rate of infant deaths attributed to birth defects is 1 in 5. The causes of about 60 percent of birth defects are currently unknown. Genetics, environmental factors, medications, and personal behavior can cause or contribute to birth defects (March of Dimes, 2004e).

While the western States generally have higher rates of infant deaths related to birth defects, Idaho ranks higher than the rest of these States on this indicator (Figure VI-9). The following graph displays the rate of infant deaths attributed to birth defects per 100,000 births for Idaho and other western States from 1996 to 2001.



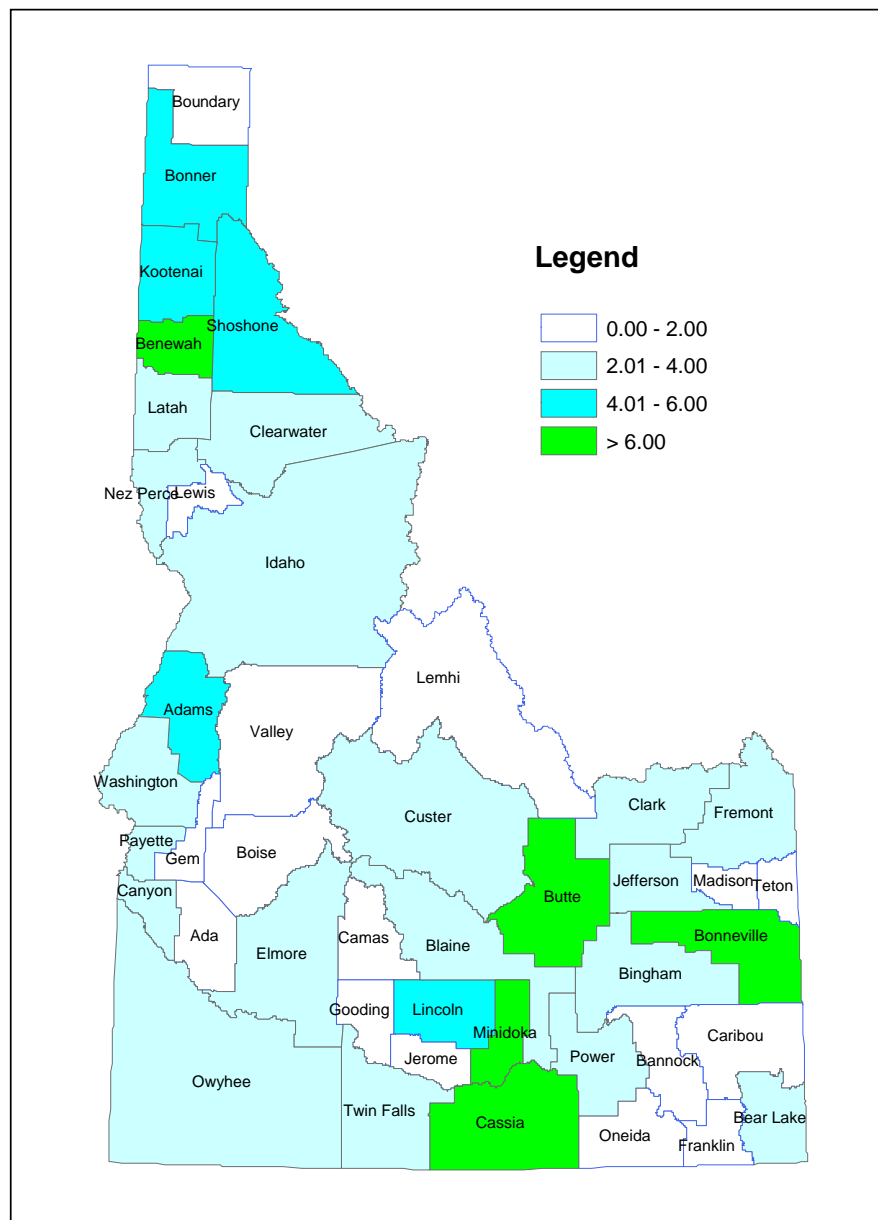
**Figure VI-9: Infant Deaths Due to Birth Defects, Idaho and West\*, 1996-2001**

\*AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

Source: March of Dimes, 2004f

The following Figure VI-10 displays the percent of congenital abnormalities per 1,000 live births by county.

## Percent of Live Births with Congenital Abnormalities



**Figure VI-10: Percent of Live Births with Congenital Abnormalities**

Source: IDHW Bureau of Health Policy and Vital Statistics, 2004

**Other causes of infant deaths.** Fifty-one (51) infant deaths were reported in 2002 under the general infant death category and were attributed to conditions that originated in the perinatal period such as LBW and infections. In the neonatal period, the second leading cause of infant death was reported as Sudden Infant Death Syndrome (SIDS). The exact causes of 36 or 28.5 percent (includes deaths reported as SIDS) of infant deaths are not reported and listed as “other causes.” Table 12 displays the causes of infant deaths.

<b>Table VI-11. Causes of Idaho Infant Death by Neonatal and Postneonatal Periods - 2002</b>						
	<b>Total</b>		<b>Neonatal</b>		<b>Postneonatal</b>	
<b>Cause of Death**</b>	<b>Number</b>	<b>Rate</b>	<b>Number</b>	<b>Rate</b>	<b>Number</b>	<b>Rate</b>
All causes	126	605.5*	84	400.5	43	205.0
Congenital anomalies (Congenital malformations, deformations, and chromosomal abnormalities)***	39	186.0	29	138.3	10	47.7
Influenza and pneumonia	1	.8	1	4.8	-	-
<b>Conditions Originating in the Perinatal Period</b>						
Other conditions originating in perinatal period	21	100.1	20	100.1	-	-
Disorders related to short gestation and unspecified LBW	12	57.2	12	57.2	-	-
Newborn affected by maternal complications of pregnancy	8	38.1	8	38.1	1	4.8
Newborn affected by complications of placenta, cord, and membranes	5	23.8	5	23.8		
Respiratory distress of newborn	3	14.3	3	14.3	-	-
Intrauterine hypoxia and birth asphyxia	2	9.5	2	9.5		
Infections specific to the perinatal period	2	9.5	2	9.5	-	-
<b>Deaths Reported as SIDS</b>						
	13	62.0	-	-	13	62.0
<b>Death Due to Other Causes</b>						
	23	109.7	4	19.1	19	90.6

\*Per 100,000 live births

\*\* Data by cause of death based on ICD-10 codes

Source: IDHW Bureau of Health Policy and Vital Statistics, 2004

In Idaho, the preponderance of infant deaths occurs in the neonatal rather than the postneonatal period. As described previously neonatal and postneonatal mortality are examined differently as the primary prevention opportunities differ in accordance with the period in which the death occurred. For example, VLBW-related deaths can best be prevented by addressing maternal health issues and by preventing and treating prematurity. Neonatal deaths can best be prevented by providing optimal newborn care and postneonatal deaths by improving infant care.

The data reveal that congenital malformations (an abnormality present at birth); preterm and LBW births; complications of pregnancy; and complications affecting the newborn related to placenta, cord, and membranes are the major causes of infant death in the neonatal period. The most significant cause of death in the postneonatal period is reported by the State as SIDS.

SIDS is defined as the sudden death of an infant under 1 year of age that remains unexplained after a thorough case investigation. Although the SIDS designation is used in Idaho to describe several infant deaths, by definition a death can be designated as SIDS only following a thorough case investigation (National Vaccine Program Office, 2001), and this does not appear to be the case in Idaho.

Several recommendations regarding SIDS were included in the 1998 and 2000 reports of the Child Mortality Review Team, which existed at the time but has subsequently disbanded. Recommendations of the Team included the use of a SIDS investigation protocol to promote the further understanding of SIDS comprised of a thorough case investigation, autopsy (not required in Idaho), review of clinical history, and examination of the death scene to all children with presumptive diagnosis of SIDS, such as recommended by the CDC (Idaho Child Mortality Review Team, 2003). The Idaho Code requires that the county coroner, who is an elected county official, is charged with the investigation of the facts surrounding the cause and manner of death and has the authority to summon a person licensed to practice medicine in the State to help determine the cause of death and, if needed, to order an autopsy.

The Child Mortality Review Team indicated that 8 of the 11 SIDS-designated deaths in 2000 may have been preventable through the elimination of risks such as the infant being put down for sleep on their stomach, secondary tobacco exposure, and cosleeping (Idaho Child Mortality Review Team, 2003). The Review Team cited significant problems in obtaining data and reported that most SIDS-designated deaths did not have a SIDS investigation form completed and information was often missing.

In 2002, an additional 23 infant deaths were reported as “all other causes (residual)” (Idaho Department of Health and Welfare, 2004a). It would be useful to know more about the circumstances of these deaths. Comprehensive information about the cause of death permits the exploration of possibilities for the prevention of deaths.

Although the focus of this section is on infants, the problem of fetal deaths must also be considered, since fetal deaths account for a large proportion of pregnancy losses and therefore health promotion and interventions intended to improve pregnancy outcomes must also be considered. A fetal death is defined as an involuntary loss in which the fetus showed no evidence of life on delivery. Data that not only identify the number and timing of fetal deaths but that also describe the life style and medical risk factors of the pregnant women experiencing a fetal death are important to an understanding of this public health problem and how to address it. States often use a Fetal-Infant Mortality Review Team, similar to the Child Death Review Idaho used in previous years but no longer, to examine the causes of these deaths and to develop prevention activities subsequently.

According to the CDC, fetal deaths at under 20 weeks' gestation account for 49 percent of all deaths that occur between the 20<sup>th</sup> week of pregnancy and the 1<sup>st</sup> year of life (Barfield et al., 2004). One of the Healthy People 2010 health objectives is to reduce deaths among fetuses of 20 weeks' gestation or less to 4.1 deaths per 1,000 live births for all racial and ethnic population groups (U.S. Department of Health and Human Services, 2000). While there are inherent difficulties in collecting data on fetal deaths that contribute to an understanding of incidence and



the factors associated with these deaths, these data can provide information important to efforts to improve pregnancy outcomes. While the number of stillborn births is identified in Idaho, the State does not report data on fetal deaths occurring in the State.

**a. Newborn Metabolic Screening**

Idaho law requires that all babies born in the state receive a screening test for metabolic disorders that can result in mental retardation and/or other serious health problems. Idaho is a member of the Northwest Regional Newborn Screening Program and, through contract with the Oregon Public Health Laboratory, uses tandem mass spectrometry (MS/MS) technology to test for more than 30 conditions. The central screening laboratory and its follow-up team, working together with BOCAPS newborn screening staff, have developed a quality control program include ongoing education for practitioners with their screening practices. Components of the program include ongoing education assist practitioners and parents, computerized monitoring of certain screening practices, and an examination of communication channels between practitioners, the laboratory, and the follow-up team.

Reportable conditions screened for in Idaho include the following:

<b>Table VI-12. Reportable Idaho Newborn Screening Conditions</b>	
Phenylketonuria (PKU)	Biotinidase Deficiency
Congenital Hypothyroidism	Galactosemia
Maple Syrup Urine Disease	

Source: National Newborn Screening and Genetics Resource Center, 2005

BOCAPS staff have conducted training with staff from almost 30 birthing facilities across the State to promote the appropriate collection of blood specimens and the timely mailing of them to the Oregon laboratory. During the past year, this effort has significantly reduced the State's collective transit time errors to the laboratory. Instructional videos about specimen collection, purchased with Title V funds, have been provided free of charge to more than 20 of the largest birthing facilities in Idaho and to the lending library of the State's largest medical center.

Screening test kits are sold to Idaho practitioners through the State newborn screening office, and revenues from those sales cover the cost of the program with the exception of BOCAPS staff, who are funded through the Title V block grant.

The Idaho Chapter of the March of Dimes has organized a task force to examine newborn screening issues that involves State newborn screening staff, the Division of Medicaid, Blue Cross and Blue Shield medical directors, and the Idaho Hospital Association. This group is focusing on the development of newborn screening protocols and creative funding strategies to cover the high costs of formula required by individuals with PKU.

<b>Table VI-13.</b> <b>Number of Idaho Newborns Screened for Metabolic Conditions, Percent of Second Screens Performed and Number of Positive Results, 2002-2003</b>		
	<b>FY 2002</b>	<b>FY 2003</b>
Total number of births	20,970	21,802*
Number of screens performed**	20,404	21,174
Percent of 2 <sup>nd</sup> screens performed	72.4	76
Number of positives	12	23

\* 2003 preliminary data (Hamilton et al., 2004)

\*\*Evidence suggests that much of the difference between total number of births and number of screens performed may be due to a variety of birth certificate errors.

Source: Idaho Department of Health and Welfare, 2005

## **b. Newborn Hearing Screening**

The Joint Committee on Infant Hearing (JCIH) has established five benchmarks for newborn hearing screening; these include the percentage of infants screened, percentage referred, percentage rescreened, percentage rescreened who are referred, and percentage of those referred who receive follow-up (Joint Committee on Infant Hearing, 2000). In Idaho, the Council for the Deaf and Hard of Hearing is the recipient of the Early Hearing Detection and Intervention (*Idaho Sound Beginnings*) Project, awarded by the Idaho Department of Health and Welfare, and is responsible for the collection and regular reporting of data from Idaho hospitals on newborn screening activities. The following is a summary of newborn hearing screening activities for the years 2001-2003.

<b>Table VI-14.</b> <b>Newborn Screening Activity 2001-2002</b>			
	<b>2001</b>	<b>2002</b>	<b>2003</b>
# of hospitals reporting	27	31	34
Total ID hospital births reported	14,260	18,886	20,060
% inpatient hospital screens	96	97	97
% referred	16	14	10
% of screenings followed up	74	68	54
# of infants not returning for rescreen	891	883	1042
% with diagnostic follow-up	56	70	100
# of infants confirmed with hearing loss	48	33	31

Source: Idaho Council for the Deaf and Hard-of-Hearing, 2004

The Council for the Deaf and Hard-of-Hearing reports that the 34 of 35 hospitals are participating and over 97 percent of Idaho's babies are born where hearing screening is performed. Newborn hearing screening is not mandated in Idaho (Idaho Council for the Deaf and Hard-of-Hearing, 2004).

The JCIH benchmarks are used to assess hospital newborn screening activities; as reported for the first 6 months of 2004, 7 Idaho hospitals exceeded the JCIH benchmarks, 15 were below 1 benchmark, 10 below 2 benchmarks, and 1 below 3 benchmarks. These are all improvements from data reported for 2003. Fourth-quarter data for 2004 indicates that the percentage of infants returning for the second screening continues to increase (Idaho Council for the Deaf and Hard-of-Hearing, 2004).

As noted earlier, not all births in Idaho occur in hospitals. In 2002, 145 infants were born in a birthing facility and 351 born at home (Idaho Department of Health and Vital Statistics, 2004a). Out-of-hospital birthing facilities make various arrangements for newborn screening. Families may also take their infants to the Infant-Toddler Program for free screening. The Council reports working with the birthing centers, midwives, and childbirth educators to inform parents of the importance of newborn hearing screening and the resources available to obtain the screening.

The hospital performing the initial screen notifies the Council of infants requiring a follow-up screen who have not been brought for the screen within 1 month. The Council follows up with the family and refers them to the Infant-Toddler Program. Infants with a confirmed hearing loss are enrolled in the Infant-Toddler Program, which then works with the family to establish a medical home for the infant. The Infant-Toddler Program coordinates with the Idaho School for the Deaf and Blind, which works with children ages 0-21 and their families around an array of issues related to the hearing loss. The Council reported an overall 97 percent newborn hearing screening rate for hospital births in Idaho in 2003 (Idaho Council for the Deaf and Hard-of-Hearing, 2004).

While significant progress is being made in the State with newborn hearing screening and follow-up, several issues remain as reported by key informants. These include improving overall screening rates and the management of newborn screening for infants not born in a hospital, strengthening follow-up of infants requiring repeat screens and diagnostic follow-up, bringing all hospitals into compliance with JCIH benchmarks, and assisting families with the acquisition of hearing aids for their infant or toddler with hearing loss

### **3. *VLBW or preterm babies are born in facilities equipped to care for them.***

The availability of neonatal intensive care has improved outcomes for high-risk infants including those born preterm or with serious medical or surgical conditions. The concept of regionalized perinatal care was articulated in the 1976 March of Dimes report *Toward Improving the Outcome of Pregnancy* and endorsed in the American College of Obstetricians and Gynecologists (ACOG) guidelines (Committee on Perinatal Health, 1976). The March of Dimes report included criteria that stratified maternal and neonatal care into three levels of complexity and recommended referral of high-risk patients to centers with the personnel and resources needed for their degree of risk and severity of illness.

The establishment of uniform definitions of levels of care offers many advantages that may improve infant outcomes and provide the basis for policy decisions that affect allocation of resources. Standard definitions permit policy and program comparisons, help consumers to understand health care options, and, most importantly, facilitate the development and

implementation of consistent standards of service provided at each level. The appropriate matching of levels of complexity of neonatal care to patient needs requires recognition of risk factors. Most studies that link neonatal outcomes with levels of perinatal care indicate that morbidity and mortality for VLBW infants are improved when delivery occurs in a subspecialty facility rather than a basic facility. Since transfer of the infant can negatively impact neonatal outcomes, it is important, to the extent possible, that high-risk infants are delivered in a facility capable of providing the anticipated appropriate level of neonatal intensive care unite (NICU) care (Committee on Fetus and Newborn, 2004).

The following are definitions of levels of neonatal intensive care recommended by the American Academy of Pediatrics:

- **Level I (basic):** A hospital nursery organized with the personnel and equipment to evaluate and provide postnatal care of healthy newborn infants, stabilize infants born at 35 to 37 weeks' gestation and provide care for those who remain stable, and stabilize infants born at less that 35 weeks' gestational age or ill until transfer to a facility who can provide the appropriate level of care.
- **Level II (specialty):** A hospital special care nursery organized with the personnel and equipment to provide care to infants born at more than 32 weeks' gestation and weighing more than 1,500 grams who have physiologic immaturity or are moderately ill with problems that are expected to resolve rapidly.
- **Level III (subspecialty):** A hospital NICU organized with the personnel and equipment to provide continuous life support and comprehensive care for extremely high-risk newborns and those with complex and critical illnesses (Committee on Fetus and Newborn, 2004).

The Idaho Hospital Association identified the hospitals with NICUs, and then each hospital was surveyed to learn how the hospital designates the level of neonatal care provided. Table VI-15 displays the responses of the hospitals.

<b>Table VI-15. Idaho NICUs by Level</b>		
<b>Hospital</b>	<b>Location</b>	<b>Level</b>
Eastern Idaho Regional Medical Center	Idaho Falls, Bonneville County	Level II
Magic Valley Regional Medical Center	Twin Falls, Twin Falls County	Level III
Portneuf Medical Center	Pocatello, Bannock County	Level II
Saint Alphonsus Regional Medical Center	Boise, Ada County	Level II
St. Joseph Regional Medical Center	Lewiston, Nez Perce County	Level III
St. Luke's Medical Center	Boise, Bannock County	Level III

Source: Hospital Telephone Survey, 2004

### ***What Do Parents Say About Their NICU experiences?***

*Parents in the Pocatello, Orofino, and Bonner's Ferry area focus groups described varied experiences in how complications were handled by hospitals. A common complaint expressed was the lack of information provided to parents about the care provided to their babies while in the NICU. The social workers associated with the NICUs got mixed reviews, with some reported as helpful and others not. Some parents particularly complained about their hospital experiences around the birth of premature babies, saying that the health care professionals did not listen to their concerns because they were first-time mothers. Others, however, said they were provided with the information they needed and especially appreciated the follow-up calls they received from the hospital because their baby was premature.*

While the Idaho Administrative Code, Standards for Hospitals in Idaho Section 400 Maternity and Newborn Service identifies requirements for basic newborn care, it does not make mention of requirements for neonatal intensive care. It does, however, require that hospitals have a policy for types of high-risk mothers and infants admitted and policy and procedure for consultation with and/or transfer to a NICU for high-risk infants (Idaho Administrative Code 16.03.14). This suggests that the hospitals have the capability to collect information about the admissions of high-risk mothers and infants that could be useful to a better understanding of the nature of the risk and the characteristics of the mothers and infants. This, in turn, would be helpful in assuring the availability of risk-appropriate care.

While Idaho reported in the States' 2004 Title V Block Grant application that 72.8 percent of VLBW or preterm infants were born in a facility equipped to care for them on 2003, information was not available about the source of the 2003 data. Data for 2004 was also not available. The Bureau of Vital Statistics indicated that this information could not be obtained from the hospitals due to confidentiality issues. Consequently, due to the lack of access to hospital data, the hospital locations and levels of NICU care provided to these infants are unknown. Also unknown are the number of VLBW or preterm infants born at each facility, the number of these infants who were transferred into each facility, and the characteristics of mothers giving birth to these high-risk infants. This information would be invaluable in assessing the effectiveness of regionalization and how it could be further strengthened to promote positive births outcomes. Matching the risk of the mother and/or infant with a facility that has the ability to manage their care adequately goes a long way to decreasing immediate and long-term complications and costs. Regionalization of perinatal care has repeatedly been demonstrated to decrease the mortality and morbidity of high-risk infants (McCormick et al, 1985; Cooke, 1987).

Idaho PRATS data does provide some data about experiences of parents with infants admitted to a neonatal intensive care nursery following delivery. Overall, 9.0 percent of Idaho resident adult mothers responding to the 1999 PRATS survey reported that their new baby was placed in a NICU after delivery (Idaho Department of Health and Welfare, 2001). The majority of these infants were placed in a NICU at the same facility where the delivery occurred. Only about one in four mothers whose baby was admitted to a NICU was told about community support programs like the Infant-Toddler Program or the Children's Special Health Program.

**3. *Infants are welcomed into a family, a home, and a community that is prepared to care for them.***

Families are reconfigured at the birth of their first child and continue to readjust as a family unit with each succeeding birth. Parents and other family members are the most important people in the lives of infants and have the primary responsibility for guiding their children to healthy, productive, and satisfying adulthood. In this most important of all roles, families need access to an array of community resources to nurture their infants in a loving, safe, and secure environment. In short, parents need to provide a roof over the heads of their families, put food on the table, and get their young children ready for life. Economic, housing, food, and health care access security are all factors that directly impact health status and must be a part of every discussion about maternal, child, and family health.

The preceding section of the report contains a detailed description of family security needs. A family prepared to welcome an infant is one that is economically secure, has access to adequate housing and food, and can obtain health care for all its members. Family security is tied to the ability of the community to provide employment that offers families a living wage, housing stock that is safe and affordable, access to nutritious food, and a health care system that is responsive to the needs of families. In addition, families need access to systems and services in their community that can provide them with information, education, and support needed to sustain the family unit and promote the health and well-being of its members.

***What Do Parents Say?***

*Mothers in the Pocatello, Orofino, and Bonner's Ferry areas talked about their experiences following the birth of their babies. A common theme expressed by these mothers was the lack of information they were provided regarding what to expect after the delivery of their baby. While they cited several activities that were helpful, including receiving brochures and some training such as baby CPR from the hospital and some access to lactation specialists, overall the mothers wanted more.*

Parents participating in the Idaho Family Survey indicated a need for assistance around feeling overwhelmed by the birth of their baby and for their feelings of sadness or depression. Of the 460 parents who responded to a question about “feeling overwhelmed,” almost 23 percent reported needing help in this area but being unable to find and use assistance that was helpful. Responses to a similar question about feeling “sad, blue, or depressed” revealed that 19 percent of the parents needed help with these feelings but were unable to find and use help that was useful to them. Another 19 percent of respondents indicated needing someone to care for their infant while they were at work or school and being unable to find and use help.

There are several community-based programs in Idaho designed to prepare families for the arrival of their infants and to support them in their role as parents. Several examples are provided below.

## a. Parents as Teachers Program

PAT is a voluntary program offered free to any expectant parent or those with children newborn to 5 years of age. The University of Idaho PAT Demonstration Project reports that the 48 PAT programs located in the State provided services to over 1,575 families and 2200 children in 2004 (Idaho Parents as Teachers, 2004). In 1999, at the request of the Governor, 13 of these sites were initiated as demonstration projects to permit a comprehensive assessment and evaluation of PAT. The program provides parents with the information and support they need to give their child the best possible start in life. The program is based on the philosophy that parents are their children's first and most influential teachers. PAT uses the Born to Learn curriculum that translates information on early brain development into concrete, "when, what, how, and why" advice for families.

A survey of parents enrolled in the 13 demonstration sites from 2001-2004 was conducted by the University of Idaho PAT program to assess program outcomes. Program activities and outcomes from the survey reported in 2004 include:

- **Home Visits.** The personal home visit offer parents personal time, one on one, in which information about child development and child rearing information is shared and a partnership formed between the parent and the trained parent educator.
  - *Ninety-five (95) percent of parents rated the personal visits as very helpful.*
- **Parent Involvement.** Educators demonstrate an activity and then get the parent involved in trying the activities with their child. Parents then repeat these activities with their child and as a result increase their ability to identify their child's needs and respond effectively.
  - *Eighty-five (85) percent of families use the PAT follow-up activities more than half the time.*
- **Group Meetings.** Monthly group meetings of PAT families allows parents to learn from each other, share common experiences and concern, develop lasting friendships, and form new support networks.
  - *Parents report their connections to other families increased as a result of PAT.*
- **Screenings.** Regular developmental screenings can expose potential problem areas which may inhibit learning. This screening provides parents with information and guidance about their child's development and emerging skills. When an educator and a parent identify a concern, an appropriate referral is made and the family is supported in addressing the need.
  - *A total of 1,693 children were screened for development, hearing, and vision.*

- ***Literacy Development.*** Research in literacy shows that the foundations of literacy are laid well before children come to school. The PAT Program helps parents develop strategies to help their children learn in the early years.
  - *Parents in PAT significantly increased the amount they read to their children (Idaho Parents as Teachers, 2004).*

## b. Children's Trust Fund

The Idaho Children's Trust Fund was established by an act of the State legislature in 1985 to promote child and family well-being in the State of Idaho in the belief that the best way to prevent child abuse and neglect is to support families and provide parents with the skills and resources they need to raise healthy children. The Trust Fund makes grants and provides training and technical assistance to programs throughout the State that work directly with children and their families. While located within State government, the Trust Fund is a unique public-private partnership that receives no State general funds and is supported by private citizens who raise funds for community grants.

For the fiscal year 2004-2005, 22 communities received funds to support families (Idaho Children's Trust Fund, 2004). These programs included a focus on assuring prenatal care for pregnant women, providing education and support for new moms, and organizing and conducting parenting classes for both mothers and fathers. Health District I conducts a program targeted to parents of infants born prematurely and/or who are medically fragile or developmentally delayed. The Trust Fund emphasizes outcome accountability and defines this as "identifying the positive changes that are expected for participants in programs, measuring the extent to which these changes did or did not occur" (Idaho Children's Trust Fund, 2004).

Examples of Trust Fund-sponsored outcomes include:

- ***ICARE, Inc.*** Coeur d'Alene provided Love and Logic parenting classes to 336 parents who reported feeling less stressed and more competent in managing discipline as a result of participation in the classes.
- ***The High Risk Infant/Toddler Project***, managed by the Panhandle Health District in northern Idaho, reported that 155 parents who received services via home visits indicated increased knowledge of child development, parenting skills, and ways to reduce family stress (Idaho Children's Trust Fund, 2004).

## c. Parents Encouraging Parents (PEP)

PEP is a nonprofit organization with a mission of promoting the health of families in all aspects (physical, mental, social, and emotional), strengthening family structures, and increasing parenting skills (Parents Encouraging Parents, 2004). Both online and community-based parenting classes are offered across the State. Data about participation and program outcomes are not available.



#### **d. Community Family Support and Education Programs**

An array of family-focused programs is available in a variety of communities across the state with some sponsored by hospitals, nonprofit agencies, and the faith community. They provide services ranging from warmlines to obtain information and guidance about parenting issues to the conduct of educational and counseling programs. Several of the agencies also offer assistance to promote family security in relation to income, housing, food, and access to health care. Many of these programs are included in the Idaho CareLine database. Data about family participation and program outcomes are not available.

It should be noted that while some areas, like Boise, have a number of family support and education programs available, other areas have very limited access to these programs.

#### **4. *Infants appropriately receive ongoing comprehensive preventive and primary care***

Since the number of infants and children in the State eligible for Medicaid is not available by age, the number of infants eligible for the program and the ratio of those eligible to those enrolled in Medicaid and EPSDT are not known. The primary discussion of the overall Medicaid program is included in the Infrastructure Section of this document. Briefly, the EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. The purpose of the program is to meet the health needs of children through the conduct of initial and periodic health examinations and evaluations and to assure that the health problems found are diagnosed and treated early, before they become more complex. EPSDT covers medically necessary diagnostic and treatment services to address conditions or illnesses identified via the screening activities.

Infants should have well-child (EPSDT) checkups at:

- Under 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months.

These checkups should include a comprehensive health and developmental history, a developmental assessment, a comprehensive unclothed physical examination, appropriate immunizations, laboratory tests appropriate for age and risk factors, and health education and anticipatory guidance for the infant's parents or caretakers.

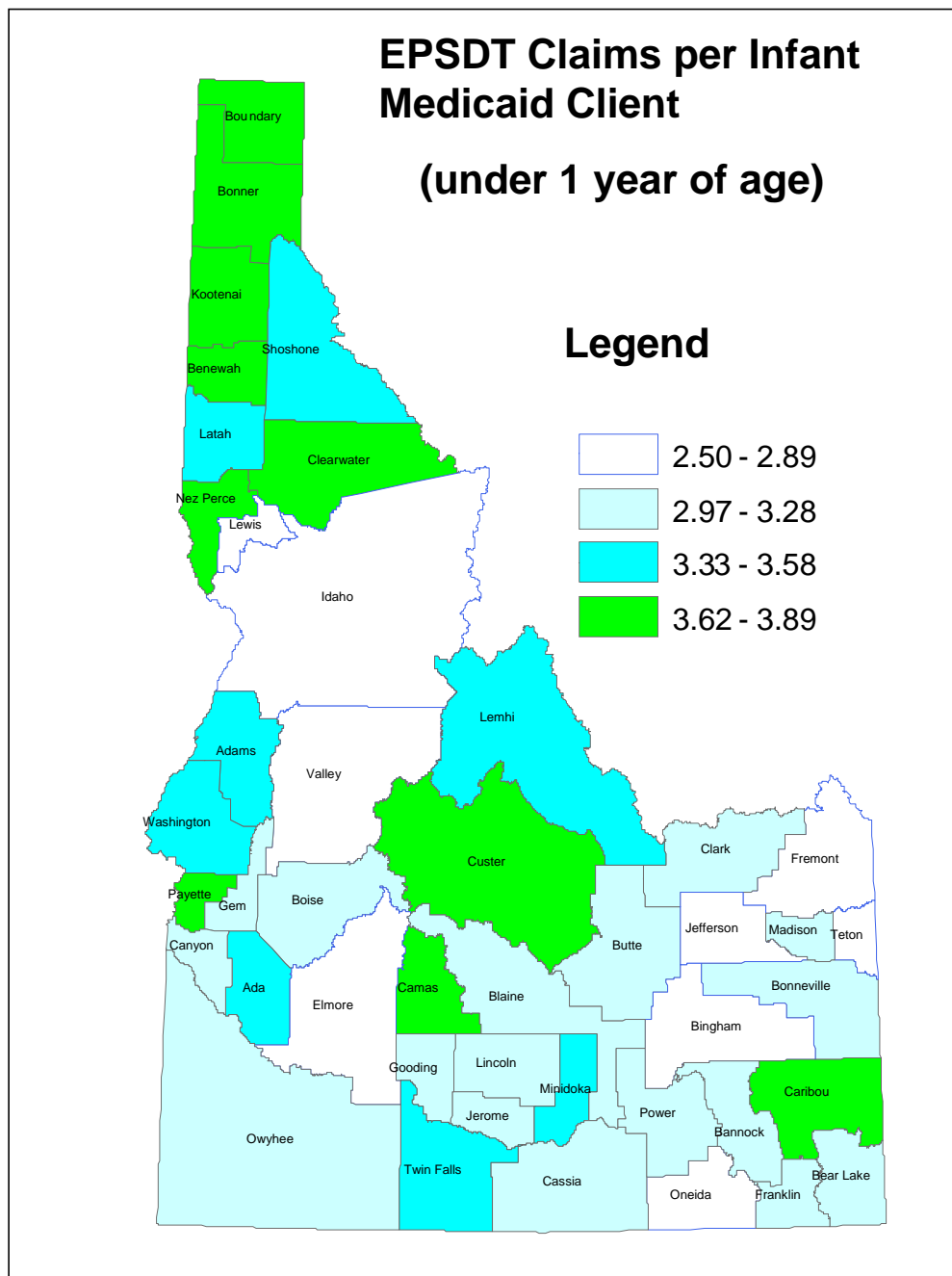
Table VI-16 displays the number of infants (under 1 year of age) enrolled in the Idaho EPSDT Program and screenings reported during the period October 1, 2002, to September 30, 2003.

<b>Table VI-16. Annual EPSDT Participation Report – Idaho 10/02-9/03</b>	
<b>EPSDT</b>	<b>Number of Children Less than 1 Year Old</b>
Number of eligible infants	10,835
Total eligible infants receiving at least one screening	6,019
Expected number of screenings per eligible Infant	3.15
Expected number of initial or periodic screening services	34,130
Actual number of initial or periodic screening services	16,452
Total number of eligible infants referred for corrective treatment	0
Total eligible infants enrolled in managed care	5,203
Total number of screening blood lead tests	12

Source: Centers for Medicare & Medicaid, 2005

With almost 50 percent of the infants reported as enrolled in managed care (Centers for Medicare & Medicaid, 2005), it would appear that there may be opportunities to increase the number of screenings, although it is not clear from the data what percentage of the screenings are attributed to infants enrolled in managed care.

As displayed on the Figure IV-11, which shows EPSDT claims per client among infants enrolled in Medicaid during 2003, the highest rate of utilization of EPSDT occurs in the northern counties, two central Idaho counties, and the population centers in the southern section of the State. Overall, it appears that a significant number of infants eligible for EPSDT visits are not obtaining the services they need. There may be data issues related to EPSDT reporting, as surely more than two infants were referred for treatment following an EPSDT screen.



**Figure VI-11: EPSDT Claims per Infant Medicaid Client**

Source: Idaho Medicaid Office, 2004

The EPSDT or well-child visit presents an opportunity not only to assess the health and development of the infant but to address the concerns of the infant's parents. Several key informants indicated during interviews that developmental screening of infants by physicians other than pediatricians is not standard practice.

Another opportunity for screening available to parents who have delivered a newborn in a hospital setting is a tool designed to help them understand their infant and toddler's

development. Parents return the completed tool to the DHO who then review them and forward surveys to the ZERO TO THREE Program for follow-up when a concern is raised about the infants' growth and development. In 2003, 5,500 tools were sent to new parents.

Responses to the Idaho Family Survey revealed that almost 57 percent of families surveyed reported that they did not need help finding a health care provider for their infant. Another 39 percent indicated that they had needed assistance locating a provider and had been able to use successfully the information they found.

The PRATS, described under the previous set of outcomes, also includes information about preventive care for infants.

<b>Table VI-17. PRATS Survey Responses – Infant Preventive Care</b>			
<b>PRATS question:</b>	<b>1999 Yes</b>	<b>2001 Yes</b>	<b>Comments</b>
<b>Used car seat bringing infant home from hospital?</b>	98.5%	99.4%	Does not reveal if car seats properly installed or in ongoing use.
<b>Place infant on back to sleep?</b>	63.2 %	68.1%	Although in 1999 63.2% reported doing this “most of the time,” an additional 8.4% reported placing the infant on his/her back “much of the time.” The reported rate for back to sleep increased in 2001.
<b>Infant exposed to secondhand tobacco?</b>	3.3%	7.7%	In 1999, only 3.3 percent of mothers reported that their new baby had some daily exposure to environmental tobacco smoke. The reported rate more than doubled for 2001.
<b>Infant up to date with immunizations?</b>	89.5%	81.0%	Mothers who reported that they had not wanted to be pregnant then or at any time in the future were less likely to have their baby's immunizations up to date than mothers who had want to become pregnant. Mothers with babies not up to date with their infant's immunizations were asked to identify the reasons for this. One (1) out of 4 mothers indicated that they thought immunizations were not safe; another 22.3 percent indicated that they had too much going on, while an additional 13.4 percent indicated that they did not have enough money or insurance to pay for it. Ten (10) percent or less of mothers indicated that lack of transportation childcare, knowledge of where to go, and/or appointment availability prevented them from getting immunizations for their infant. Fewer than 20 mothers reported not understanding the immunization scheduled as the reason why they had not fully immunized their new baby.

Sources: 1999 data is from Idaho Department of Health and Welfare (2001) and 2005a

### ***What Do Parents Say?***

*Mothers in the focus groups conducted in Pocatello, Orofino, and Bonner's Ferry were asked about well baby visits; many indicated they skipped some of these because of the cost and took their baby instead to the local health department for immunizations.*

## **Parenting Education and Support**

Few events are as life changing as becoming a parent. This is also an event for which most first-time parents feel inadequately prepared. The need for more parenting education and support services was identified at each of the Early Childhood Early Learning Task Force regional meetings conducted across Idaho, indicating that the need for parenting education and support is a statewide issue. In these meetings, parents reported being faced with simultaneously financial issues; the responsibility of maintaining a home; and providing for the developmental, social, and emotional needs of their children. Mothers and fathers said they tend to parent the way they were parented because this is what they know but felt that they needed other guidance as well. Often, extended family is not available to support these parents and lend a hand when needed.

Support services also need to be available to grandparents who are raising their grandchildren. In 2000, there were 8,110 grandparents who reported they were responsible for their grandchildren (GrandsPlace, 2002). Two (2) percent of these grandparents are African American, 12 percent are Hispanic, 1 percent are Asian, 4 percent are American Indian or Alaskan Native, and 79 percent are White. Forty-three (43) percent of these grandparents live in households without the children's parents present. Over 700 of the grandparents live in the Boise area. In Idaho, there are 13,636 children living in grandparent-headed households; this represents 3.7 percent of all the children in the State.

Idaho has developed several kinship care programs to assist these grandparents and other nonparental caregivers. These include the Idaho Kincare Coalition, the Commission on Aging, the AARP State Office, the Cooperative Extension, and several other community-based groups.

The following is a summary and analysis of key findings.

## **Summary Findings and Analysis**

### **Idaho Infant Outcomes**

**Infants are born at term, of normal weight, without preventable congenital defects and are appropriately screened for potential problems.**

#### **Summary**

- While Idaho compares favorably with overall national data for birth outcomes, there are population groups with rates of premature and LBW births, birth defects, and infant mortality that are of concern. These problems generally occur in the most rural counties and those with higher numbers of Hispanic residents.
- There are an array of agencies, organizations, and stakeholders providing various

### Idaho Infant Outcomes

aspects of care to promote positive birth outcomes.

- There is insufficient data available regarding program utilization and outcomes.
- Important hospital data is not available.
- With the demise of the Child Mortality Review Team, infant deaths are not reviewed for preventable causes.
- A growing number of births are occurring outside of hospital settings.

#### Analysis

- Overall services and care appear fragmented, which reduces the effective use of existing resources. Continuity of risk-based perinatal care is important to the promotion of positive birth outcomes. It is important that the perinatal system also include prenatal, delivery, and follow-up care provided by midwives.
- The lack of meaningful outcome-focused program data is a barrier to assessing the effectiveness of activities, which results in lost opportunities to allocate resources to efforts that are effective.
- The state's neonatal and postneonatal death rates, as well as the infant mortality rates, provide guidance as to interventions needed to avoid these deaths. Understanding when deaths occur by examining perinatal periods of risk permits the appropriate focusing of interventions.
- Not all deaths attributed to SIDS appear to be comprehensively investigated using CDC guidelines and the causes of other infant deaths are not described in the available data. The investigation of infant deaths can be a very important public health tool that can lead to policies and interventions that will prevent future deaths.
- Idaho reports very high rates of deaths due to birth defects. The lack of a birth defects registry impedes the identification and tracking of infants and services and could be useful to an array of programs including newborn screening and child finding.

### **VLBW or preterm babies are born in facilities equipped to care for them.**

#### Summary

- When infants at risk are born in a facility prepared to care for them, birth outcomes improve. The lack of specific data indicating the overall rate and characteristics of these infants born in appropriate facilities significantly limits an assessment of the effectiveness of regionalization and access to the appropriate level of care for high risk infants.

#### Analysis

This lack of data limits the opportunity for a collaborative exploration of problems related to high risk births and the development of collective solutions. Important to the achievement of “data-driven” systems of care is the availability of data from all sectors of the system, including hospitals.

**Infants are welcomed into a family, a home, and a community that is prepared to care for them.**

### **Summary**

- Many working Idaho families are economically insecure and the extent of this insecurity varies greatly across the state.
- Idaho TANF monthly benefits are significantly lower than benefits in surrounding States.
- There are no TANI (Idaho TANF) work exceptions for parents caring for children with significant health or disabling conditions.
- A significant percentage of Idaho families are housing cost burdened forced to pay a high percent of their income to pay for housing.
- African Americans and Hispanics have disproportionate rates of homelessness.
- Migrant and seasonal workers are often at considerable risk for inadequate housing.
- In Idaho 13.7 percent of households (as compared national rate of 11 percent) are food insecure.
- Idaho ranks 28<sup>th</sup> of all the States in overall State food participation rates.
- Education and support programs are available in some sections of the State and accessible to some, but not all, parents.
- A significant number of parents indicate a need for emotional support and are unable to find assistance that is helpful to them.

### **Analysis**

- Adequate family income, housing and food are essential to a family's ability to care for their infants. The data suggests that many families are struggling to obtain access to basic needs; particularly in need or single mothers, migrant or seasonal workers, and Hispanic and African American families.
- Policies and programs related to any aspect of economic security, housing, and food availability should take into account their importance to MCH outcomes.
- The involvement of MCH stakeholders in policies and programs that focus on the economic, housing, food, and health care access security issues can promote collaboration on these issues.
- A number of agencies are focused on activities designed to strengthen families and community support, but these efforts appear fragmented at the State and local levels. There are no overarching family outcomes or program data collection methods in place.

## **Infants appropriately receive ongoing comprehensive preventive and primary care.**

### **Summary**

- A significant number of infants did not receive the prescribed number of EPSDT screens.
- No infants of the total screened were reported as referred for treatment.
- For infants as a group, limited data is available to assess the extent that they receive ongoing comprehensive preventive and primary care.
- The State does not recommend and subsequently promote a health supervision guide focused on comprehensive preventive and primary care.

### **Analysis**

- Limited data is available to provide information about the level of comprehensive preventive and primary care received by infants.
- While EPSDT is available to infants only when they are enrolled in Medicaid, it is a program that can assure that infants are screened for both health and developmental status and referred appropriately. This appears to be an underused opportunity in Idaho, with rates for infants in northern areas of the State higher than those for infants in other areas of the State. It would be useful to know the extent of screening for infants enrolled in managed care compared to those not enrolled in managed care.
- Without adequate data, it is difficult to know which infants are or are not receiving appropriate care. This lack of data prevents the development of appropriate strategies to promote ongoing care and a medical home.
- It is unclear what is being done in the state to promote adequate developmental screening of infants. These screenings are an important aspect of early care and education initiatives.
- The effectiveness of managed care in providing infants with a medical home is unclear.



## CHAPTER VII

### Children and Adolescents

---

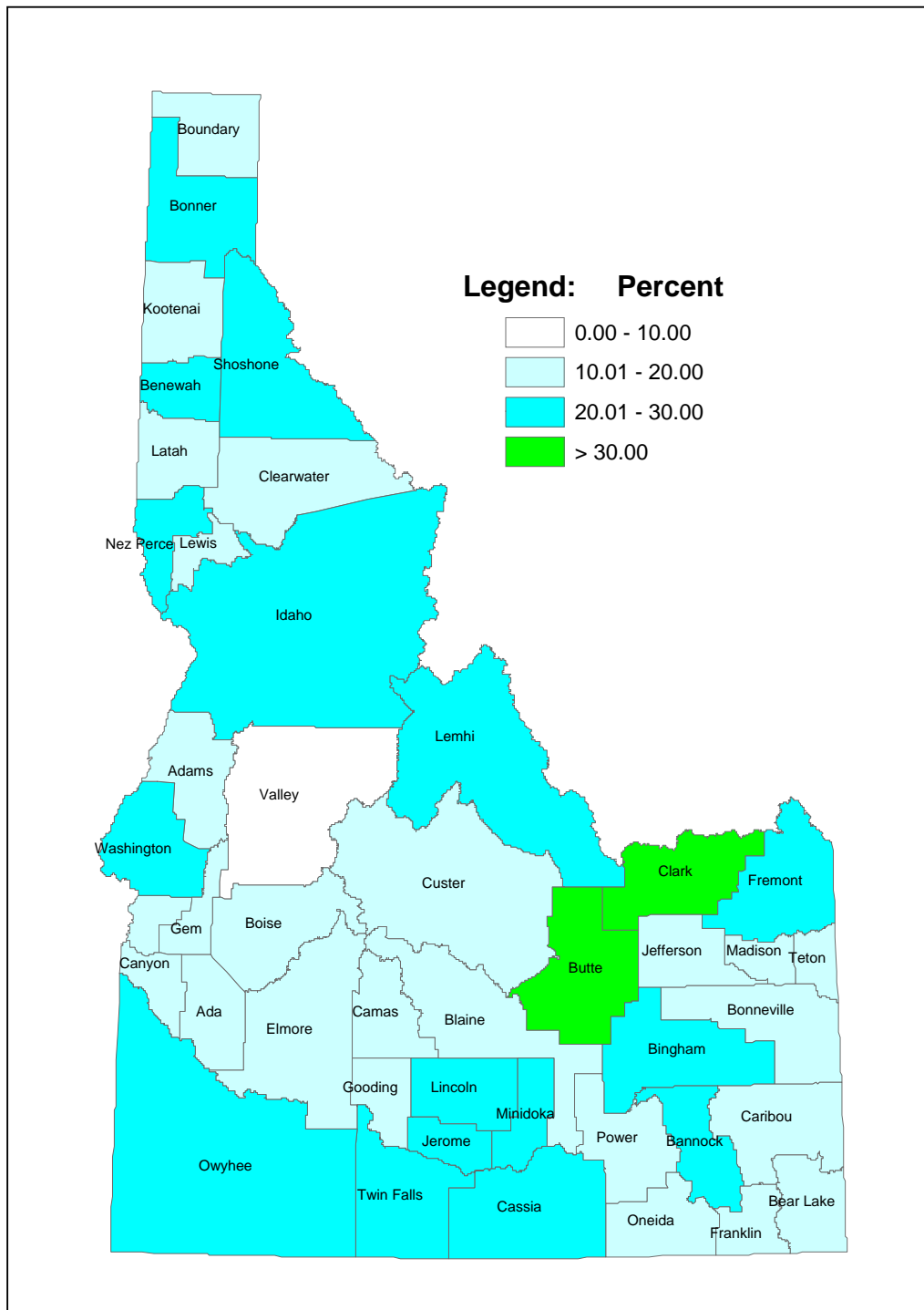
In 2004, there were 372,411 children under the age of 18 in Idaho (U.S. Census Bureau, 2004). This population represents a unique collection of health and social service needs that are constantly changing as children grow and develop with age. Children especially can be vulnerable to poor health outcomes, as they are usually solely dependent on their parents and guardians for all their health needs and thus often more sensitive to changes in family dynamics. Moreover, children have different disease patterns than adults, requiring distinctive disease prevention and management strategies. Children are more likely to have short recurrent illnesses, such as ear infections, than adults. When children do experience the same diseases as adults, they are often manifested in different ways. Important lifestyle practices such as nutrition and physical activity often begin at an early age. This time period presents an excellent opportunity to encourage healthier behavior patterns before deleterious habits become established. Upon reaching puberty, adolescents become more sensitive to peer influences and are more likely to engage in harmful risk behaviors such as using drugs and alcohol or having unprotected sex. These and other unique attributes of children and adolescents must be considered when designing programs and systems of care to promote their health and wellness (Leatherman and McCarthy, 2004).

The following section describes the current health status of children and adolescents over one year of age and the ability of State systems to address this population's needs.

#### A. Characteristics of Children and Adolescents

The number of children in Idaho under the age of 18 declined nearly 11 percent between 1990 and 2000. Still, children continue to account for a large proportion of the population. During 2000, 7.5 percent of Idahoans were under the age of 5 and another 24 percent were between the ages of 5 and 19 years. The child population has become more ethnically diverse. The proportion of Hispanic children under age 18 years has increased, from 10.5 percent in 1998 to 12 percent in 2001 (Children's Bureau, 2004a). Hispanic children are particularly likely to face severe economic pressure, as twice as many Hispanic children lived in poverty during 2000-2002 (National Center for Children in Poverty, 2005). Still, poverty is a major concern among all of Idaho's children: 19 percent of all children under the age of 18 lived in poverty during 1999, and this figure has changed little since the early 1990s (Idaho Kids Count, 2003). However, younger children in Idaho are even more at risk of living in poverty than are older children. Nearly 40 percent of Idaho's counties have more than 20 percent of children under age 5 who live in poverty (Figure VII-1), a proportion four times as high as the number of counties with greater than 20 percent of children age 5 and over that live in poverty (Figure VII-2). Poverty is one of

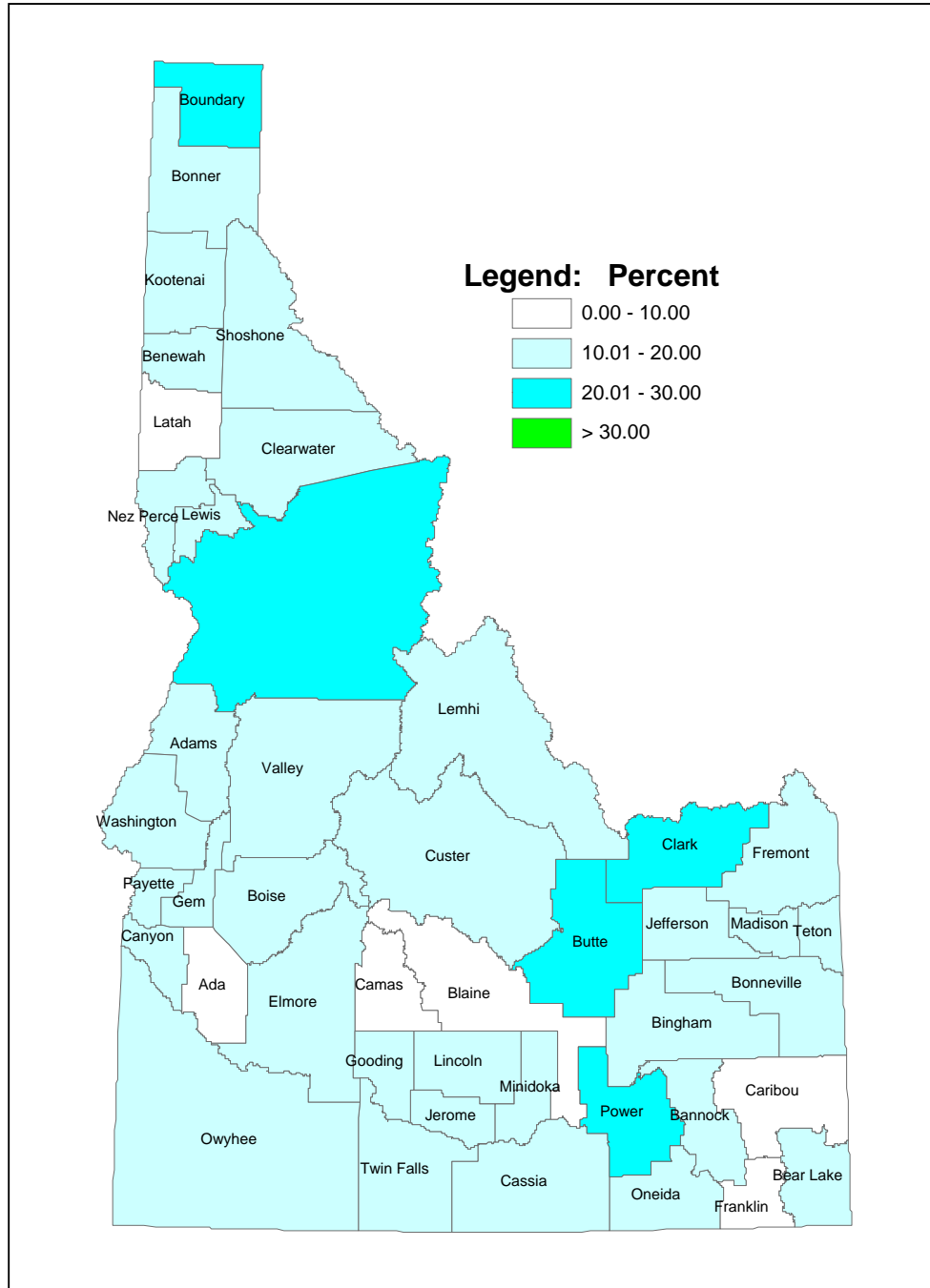
the most powerful predictors of children's health outcomes, as it affects access to a range of basic necessities of life, including health care and a healthy living environment.



**FigureVII-1: Map Displaying Distribution of Children Under the Age of 5 that Lived Below the Poverty Line in Idaho During 2000**

Source: U.S. Census Bureau, 2001

## Percent of Children 5 to 17 in Poverty in 2002



**Figure VII-2: Map Displaying Distribution of Children Ages 5 to 17 that Lived Below the Poverty Line in Idaho During 2000**

Source: U.S. Census Bureau, 2001

## B. Child and Adolescent Outcomes Examined

Five outcomes have been selected to evaluate the health and well-being of the child and adolescent population in Idaho. Attaining these outcomes will both help these children continue to develop appropriately and promote good health practices as they transition into adulthood.

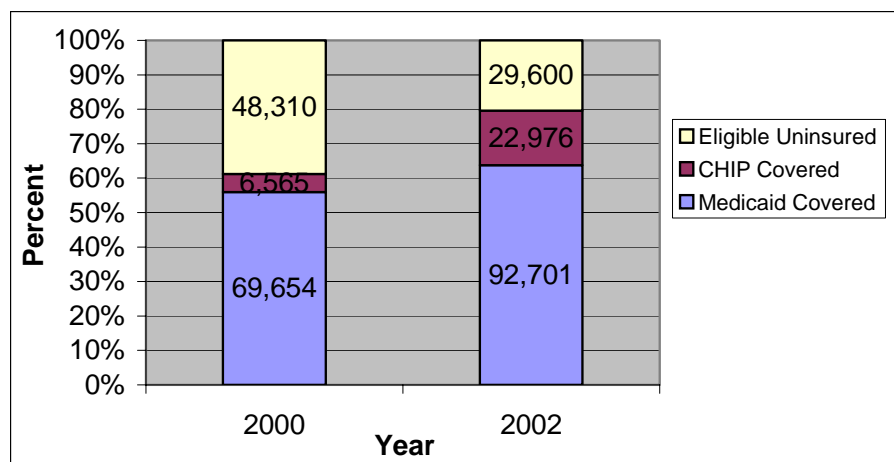
<b>Table VII-1</b> <b>Idaho Child and Adolescent Outcomes</b>
Children receive ongoing and preventive health care consistent with the Bright Futures Health Supervision Guidelines.
Children are cared for in environments that protect health, promote their well-being, and ensure their safety.
Families have access to and use services that strengthen parenting skills appropriately.
Adolescent children use ongoing health services appropriate to their stage of growth and development.
Adolescent children obtain the health and lifestyle information and education that support lifelong positive health behaviors.

### **1. *Children receive ongoing and preventive health care consistent with the Bright Futures Health Supervision Guidelines.***

Health insurance coverage is one of the main means of obtaining adequate access to ongoing and preventive health care because it significantly reduces out-of-pocket costs of care to individuals. Unfortunately, a significant proportion of children are either underinsured or uninsured. Even those with comprehensive health insurance coverage still may not have access to all the basic health services that promote good health, such as immunizations and oral health care, as well as more specialized care to prevent adverse health outcomes, such as mental health treatment.

#### **a. Insurance**

Idaho has already met the Healthy People 2010 goal to increase the proportion of nonelderly persons with health insurance to 83 percent among children. During 2002-2003, 86 percent of children under age 18 had some form of health insurance. Yet 14 percent of these children were uninsured during this time. The number of children eligible for public health insurance programs, which include Medicaid and CHIP, that have actually enrolled has substantially increased in recent years. During 2000, nearly 50,000 children were uninsured but eligible for public coverage. By 2002, this number had shrunk to 30,000 as a greater number of children were enrolled in Medicaid and CHIP (Figure VII-3). Yet this number still represents a relatively high proportion, 60 percent, of all uninsured children that were eligible but not enrolled in public insurance.



**Figure VII-3: Children's Public Health Insurance Coverage in Idaho, 2000-2002**

Source: Idaho Kids Count, 2003

Children ages 0-5 with family incomes up to 133 percent of FPL and children ages 6-18 with family incomes up to 100 percent of FPL are eligible for Medicaid. Children that from families that are over-income for Medicaid may be eligible for CHIP coverage. CHIP-A, which is a Medicaid expansion, covers children from families with incomes above the Medicaid limits and up to 150 percent of FPL. Both programs cover the same set of comprehensive benefits, including basic preventive services and a range of treatment services (Idaho Department of Health and Welfare, 2004a). The proportion of children under age 18 eligible for Medicaid or CHIP-A was 29 percent in 2002 (Idaho Medicaid Office, 2004). The proportion of children in this age group actually enrolled in Medicaid or CHIP-A increased from 23 percent during 2001-2002 to 26 percent by 2002-2003. Both of these figures were comparable to the national average proportion of children under age 18 eligible and enrolled in Medicaid and SCHIP programs (Kaiser Family Foundation, 2005a).

When CHIP-A was introduced in Idaho, there was an initial push to recruit eligible children into the program. IDHW worked with CMHCs to increase enrollment by hiring their outreach workers. During the key-informant interviews, CMHC interests indicated that the State set unrealistically high enrollment targets, such as a completed application every 15 minutes. Workers were unable to meet this expectation and instead tried to explain that they needed more time to establish trust with residents that have long held unfavorable views of public insurance.

In 1999, Idaho set a goal of increasing enrollment in Medicaid & CHIP by 8,000 children annually. This three-year goal of adding 24,000 children to the base count of 54,000 was accomplished in 18 months. From that time, the State has continues to achieve the 8,000 per annum increase. In response to the huge caseload growth, the Idaho legislature limited (for a one-year period) the amount of CHIP-A recruitment for fear of expanding caseloads beyond capacity. The State subsequently decreased usage of mass media as a primary CHIP-A recruitment tool.

Despite these recruitment concerns, the CHIP Program was recently expanded to extend coverage to a greater proportion of the near poor. As of July 2004, children from families whose incomes exceed 150 percent of FPL but are less than 185 percent of FPL may also qualify for the

new CHIP-B/Access Card Program. This flexible program allows eligible families to choose a State-managed health plan, CHIP-B, at the cost of \$15 per month or the Children's Access Card Program to join an employer-sponsored or individual health plan. The State will pay up to \$100 per child with a cap of \$300 per month per family to cover the cost of premiums. CHIP-A eligible children can also choose the Access Card program in lieu of direct benefits. The CHIP-B plan covers the same basic services as CHIP-A, but does not cover all specialized services such as dental and durable medical equipment and supplies. The comprehensiveness of benefits included in plans selected with the Children's Access Card will depend upon the policy selected by the family (IDHW, 2004a). Individual and small group policies sold in Idaho are regulated to contain a comprehensive set of benefits. The CHIP-B/Access Card Program is limited by State funding (this is a designated funding source, not general appropriations) and was estimated that 5,600 children could be covered in the first year of operation.

The majority of children in Idaho, 55 percent, are enrolled in employer-sponsored plans, a proportion similar to the United States. This proportion has decreased in recent years: 7.6 percent fewer children in Idaho have been enrolled in such plans between 2000 and 2003, compared to the slightly smaller decline of 4.8 percent of children nationwide enrolled in employer-sponsored coverage during the same time. Idaho ranks 49<sup>th</sup> for its relatively low proportion of private-sector employers that offer health insurance coverage, only 44 percent of firms in Idaho compared to the national average of 57 percent (Kaiser Family Foundation, 2004b). In addition, 5 percent of children 18 and under were enrolled in individual insurance plans during 2002-2003.

#### **What Did Parents Say?**

Many parents expressed concern that public insurance programs do not adequately cover children from near-poor families, as many earn more than the maximum income limits to qualify yet often do not earn enough money to pay the full cost of health care out of pocket. Many indicated that they would prefer to sign their children up for a public insurance plan because their employer coverage often has high deductibles or only covers the employee and not their dependents. In the Hispanic focus groups, some parents were also not able to obtain public insurance for their children because they earned too much, while others were denied coverage because their children were not yet legal citizens. Some Hispanic parents mentioned that they had an easier time getting public coverage for their children, regardless of citizenship status.

On the other hand, some parents also said that they did not want to sign up for public programs like Medicaid because of the social stigma and the perception that such programs are equivalents of handouts. Some of the providers and program directors that were interviewed also felt that a number of families that qualify for public insurance do not apply because of the stigma associated with such government programs. Therefore, the Access Card has the potential to be a more appealing option to these families by giving them greater access to less stigmatized private insurance plans.

### **b. Utilization of Primary Care Services**

#### ***i) Access to a Medical Home***

In recent years, increasing attention has been focused on ensuring that all children have access to a medical home and a regular source of primary care (Starfield and Shi, 2004). Children who lack a medical home are more likely to delay seeking care and thus receive fewer preventive services, which in turn increases the likelihood that children will be hospitalized for illnesses and

complications that could have been avoided if they had access to ambulatory care. Individuals in Idaho are more likely to lack a medical home than the rest of the nation. While about 12 percent of individuals nationwide lack regular access to a primary care provider, 20 percent of individuals in Idaho went without such access in 2003. Moreover, Idaho is a standout in Region X, as less than 10 percent of the population in Alaska, Washington, and Oregon lack access to a medical home (National Association of Community Health Centers, 2004).

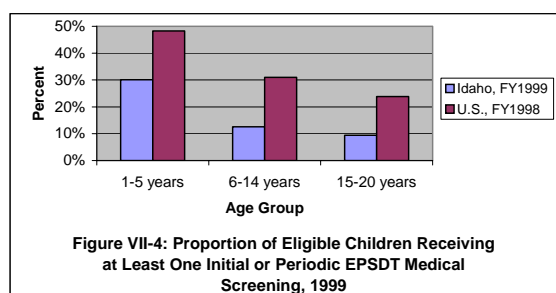
The growth of CMHCs over the last 40 years has helped to reduce significantly the proportion of children that live without a medical home. CMHCs now serve one out of five low-income children across the Nation (National Association of Community Health Centers, 2004). The proportion of pediatric patients under age 18 served at CMHCs has declined since the mid-1990s, from 45 percent in 1994 (Idaho Department of Health and Welfare, 1999) to 32 percent in 2003 (Bureau of Primary Health Care, 2004). Still, Idaho's CMHCs served nearly 20 percent of the children under age 18 living below the FPL based on 2000 Current Population Survey totals (U.S. Census Bureau, 2001), and nearly a third of these children were uninsured (Bureau of Primary Health Care, 2004). RHCs also serve a large proportion of children that lack medical homes by using physician assistants and nurse practitioners to provide Medicaid reimbursable primary care to low-income populations. There are now over 3,000 RHCs across the country (National Association of Rural Health Clinics, 2005). Unfortunately, we were unable to locate any data that tell how many children access Idaho's RHCs.

## *ii) EPSDT Compliance*

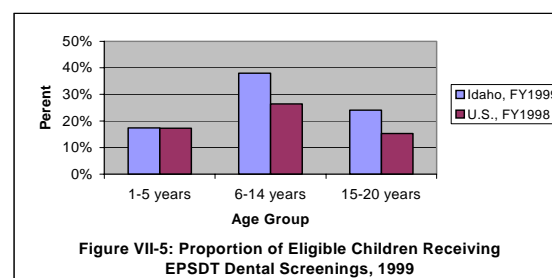
EPSDT screenings play a critical role in ensuring that at-risk children receive preventive and treatment services as they grow and develop. All children under age 21 that are enrolled in Medicaid and CHIP in Idaho are entitled to receive EPSDT screenings. Screenings are conducted at regular intervals of time, as established by the "periodicity schedule." In order to ensure that children actually receive these screenings, Congress has tried to promote outreach by requiring States to inform all enrollees of the availability of EPSDT screenings and offer support services, such as transportation and appointment scheduling assistance. Despite these measures, the EPSDT Program has experienced relatively low participation since the mid-1990s, especially among dental, hearing, and vision screenings, which have much lower utilization rates than the comprehensive medical screenings (Perkins, 1999).

The proportion of eligible children in Idaho receiving one or more medical screenings has steadily increased since the early 1990s (Centers for Medicare & Medicaid Services, 2005). However, the proportion of Idaho's eligible children receiving at least one EPSDT medical screening continued to be much lower than the national average across all age groups by the end of the decade. Medical screenings among all eligible children have been more prevalent among younger than older children. Nearly a third of children ages 1-5 have had at least one medical screening in Idaho compared to just 10 percent of children ages 15-20 years during 1999 (Figure VII-4). The most recent data for nonmedical screenings we were able to locate are from 1999. In both Idaho and the United States, the proportion of eligible children receiving additional nonmedical screenings was much lower than the proportion receiving medical screenings during this time. Among the nonmedical screenings, Idaho's children were most likely to receive dental screenings, especially when compared to the national average (Figure VII-5). Fewer than 20 percent of children across all age groups in both Idaho and the United States received vision

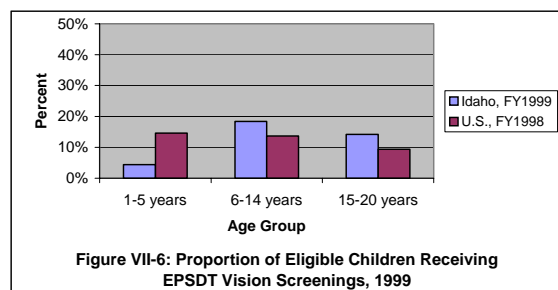
screenings (Figure VII-6). Children were least likely to receive hearing screenings, with Idaho lagging much further behind the nation; fewer than 5 percent of Idaho's children received hearing screenings across all age groups (Figure VII-7).



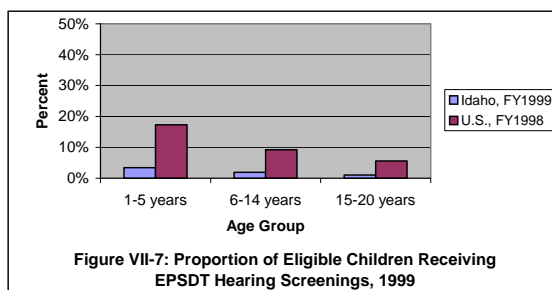
Source: Centers for Medicare & Medicaid, 2005



Source: Centers for Medicare & Medicaid, 2005



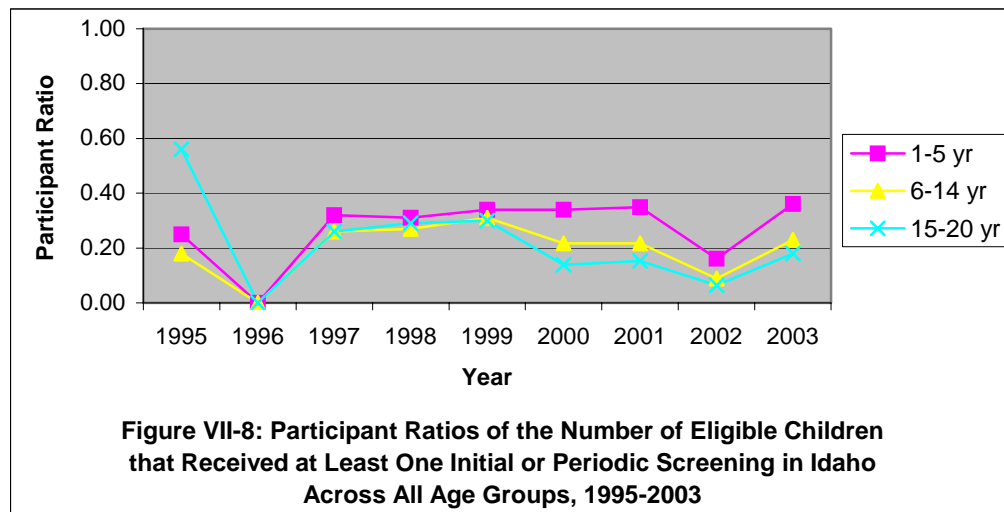
Source: Centers for Medicare & Medicaid, 2005



Source: Centers for Medicare & Medicaid, 2005



Another important trend is the large difference in EPSDT participation across age groups. Ratios compare the proportion of children eligible for screenings to the proportion that actually receive at least one initial or periodic medical screening. Younger eligible children in Idaho have been much more likely to receive screenings than older children (Figure VII-8). During 2003, twice as many eligible 1- to 5-year-olds received screenings than did eligible 15- to 20-year-olds. This trend has persisted since the mid-1990s.

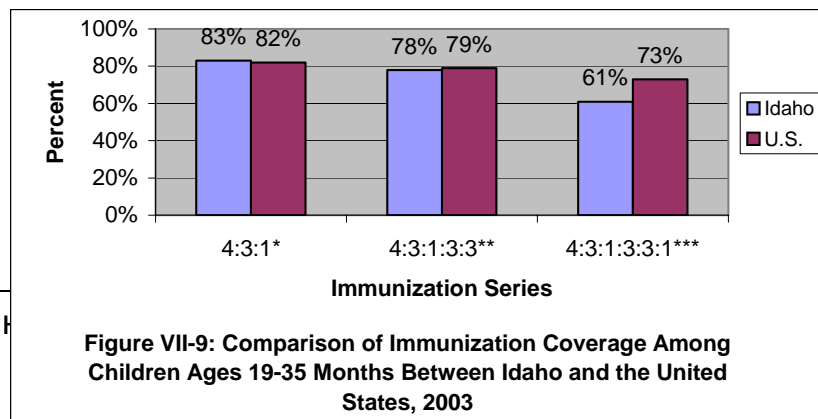


Source: Centers for Medicare & Medicaid, 2005

### iii) Immunization Rates

The introduction of vaccines in the 1940s has helped the nation reach record low incidences of once-common and often-fatal diseases like polio and measles. Moreover, administering vaccines in early childhood has helped protect the most vulnerable segment of the population, as younger children experience a higher risk of complications and death from vaccine-preventable diseases (National Immunization Program, 2005).

Idaho's young children ages 19-35 months have basic immunization coverage comparable to children across the United States, with similar proportions of young children receiving 4:3:1 and 4:3:1:3:3 vaccination series in 2003 (Figure VII-9). However, the CDC has recommended since 1996 that children also receive the varicella vaccine, which is only included in the 4:3:1:3:3:1 schedule, during routine visits by the time children reach 18 months of age (Centers for Disease Control and Prevention, 1996). Significantly fewer children in Idaho received the 4:3:1:3:3:1 series than children across the United States in 2003. All children in Idaho and across the United



States have much farther to go to meet the Healthy People 2010 goal of increasing the proportion of children 19-35 months of age that are completely up to date on immunizations to 90 percent.

Source: National Immunization Program, 2003

\*Four or more doses of any diphtheria, tetanus toxoids, and pertussis vaccines (DTP), three or more doses of poliovirus vaccine, and one or more doses of any measles or measles-containing vaccine (MCV)

\*\* Four or more doses of any DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, three or more doses of *Haemophilus influenzae* type B conjugate vaccine (Hib), and three or more doses of Hepatitis B vaccine (HepB)

\*\*\* Four or more doses of any DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, three or more doses of Hib, three or more doses of HepB, and one or more doses of varicella

There are also many important regional differences in vaccination coverage within Idaho. Table VII-2 presents the vaccination coverage of young children served in district health departments between 2002 and 2004. The proportion of children that are completely up to date on immunizations in District 7 was similar to the national average, while District 6 actually exceeded this average. Vaccination coverage in Districts 2 and 5, however, was particularly poor, as only about half of the children seen at district health clinics were up to date on the 4:3:1:3:3:1 vaccination series (Table VII-2).

<b>Table VII-2</b>			
<b>Proportions of Children Ages 19-35 Months that Have Received Vaccination Series Served at Idaho's District Health Departments, 2002-2004</b>			
<b>Region</b>	<b>4:3:1*</b>	<b>4:3:1:3:3**</b>	<b>4:3:1:3:3:1***</b>
District 1	82.3%	80.7%	59.0%
District 2	88.3%	87.3%	50.5%
District 3	81.0%	78.3%	63.5%
District 4	81.0%	78.7%	68.5%
District 5	75.5%	74.3%	52.5%
District 6	93.7%	93.3%	85.5%
District 7	90.0%	89.3%	75.0%

Source: Idaho Immunization Program, 2004

\*Four or more doses of any DTP, three or more doses of poliovirus vaccine, and one or more doses of any MCV

\*\* Four or more doses of any DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, three or more doses of Hib, and three or more doses of HepB

\*\*\* Four or more doses of any DTP, three or more doses of poliovirus vaccine, one or more doses of MCV, three or more doses of Hib, three or more doses of HepB, and one or more doses of varicella

The recent introduction of immunization registries has also helped increase the proportion of children that are up to date by tracking the immunization status as they age and making accommodations to encourage those not up to date to come in for followup visits (Every Child by Age Two, 2005). Idaho has established the Idaho Immunization Reminder Information System (IRIS) to help centralize children's immunization records. The proportion of children enrolled in IRIS has substantially increased each year since its inception in 1999. Similarly, the proportion of providers who have submitted records to the database has increased 62 percent since 2001 to a total of 176 providers in 2003. By July, 2003, 94 percent of children age 2 and

under were enrolled in IRIS. However, a much smaller proportion of older children are enrolled. During 2002, 77,025 children under age 6 had at least one immunization record in the registry, or about 64 percent of the total population under 6 (Idaho Immunization Program, 2004). This is much lower than the Healthy People 2010 goal to increase the proportion of children under age 6 who are enrolled in immunization registries to 95 percent.

The CDC immunization schedule also includes recommendations for children up to 18 years old to guide administration of catch-up immunizations during preadolescent assessment to ensure that older children missing vaccines become up-to-date. These later assessments are especially important for older adolescents who may have been born after newer vaccines were introduced and may not have received them before age 2 (Fackler, 2004). High risk groups should also be given additional age-appropriate vaccines, such as the influenza vaccine for children 6 months of age and older with certain risk factors including asthma and sickle cell disease. No statewide data could be located that evaluate the proportion of children over 24 months old that are up to date, suggesting there is a need to begin collecting and monitoring this data. IRIS will likely be an important tool to accomplish this goal as more children are enrolled and the database is streamlined.

Another important method of monitoring childhood immunization status is school entry requirements. Beginning in 1998, the CDC broadened its recommendations to incorporate the creation of school entry requirements that also include the varicella vaccine. Varicella infection can be very serious when it occurs during adolescence and early adulthood, thus making it very important to track varicella vaccination status as children age (Fackler, 2004). Idaho currently requires students entering grades K-12 to be up to date on the 4:3:1:3:3 schedule but is one of only 15 States that do not require entering secondary school students to have the varicella vaccine, which is only included in the 4:3:1:3:3:1 schedule (American Academy of Pediatrics, 2004). In addition, the IDHW, Office of Epidemiology has yet to add varicella to its current list of reportable diseases (Idaho Department of Health and Welfare, 2004e). For these reasons, no data exist that describe the State-level prevalence of varicella among children. Healthy People 2010 has set a goal to achieve a 99 percent improvement in vaccination coverage to reduce cases of varicella (U.S. Department of Health and Human Services, 2000). The vaccination coverage of varicella in children 18-35 months is about 12 percent lower in Idaho than the national average, 73 percent compared to 85 percent (National Immunization Survey, 2003). These factors make tracking varicella among Idaho's children and actively working to achieve the HP2010 goal of increasing varicella coverage among children to 90 percent very difficult.

## **c. Disease and Illness**

### ***i) Chronic Lower Respiratory Diseases***

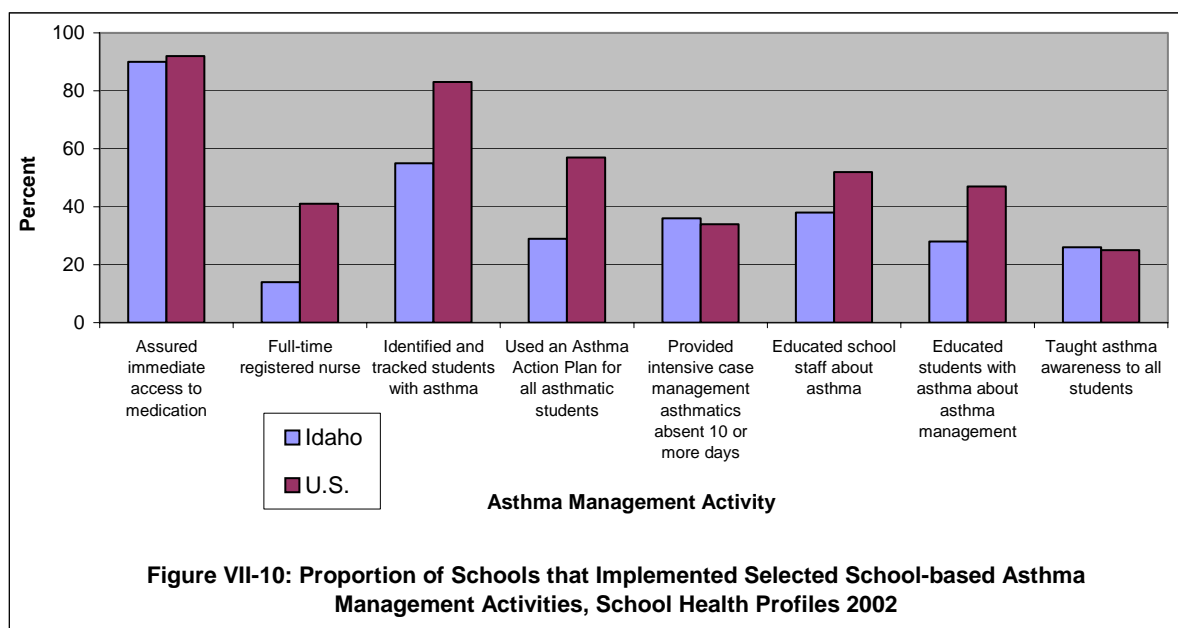
Chronic lower respiratory diseases (CLRD) include asthma, chronic bronchitis, emphysema, and other diseases characterized by permanent airflow obstruction (Idaho Department of Health and Welfare, 2001). Asthma is the most common CLRD and is one of the most common chronic childhood illnesses, affecting nearly 6 million children nationwide in 2002. The illness is characterized by ultrasensitivity of the lungs to a range of stimuli, including vigorous exercise, allergens like pet dander and cockroach dust, and cigarette smoke. Asthma is one of the leading

causes of both school absenteeism and emergency room visits (American Lung Association, 2004).

## ii) Asthma

Currently, Idaho does not have a statewide survey tool to measure the prevalence of asthma among children, which serves as a rough estimate of prevalence. However, the 2000 Idaho BRFSS asked adults about the presence of children with asthma in their households. About 15 percent of adults reported that there was at least 1 child under age 18 with diagnosed asthma (Idaho Department of Health and Welfare, 2002). Fortunately, most children have mild-to-moderate asthma symptoms than can be successfully managed with appropriate surveillance and intervention (American Lung Association, 2004).

Schools also play an important role in addressing childhood asthma. The CDC has recommended a number of strategies to help schools create coordinated school health programs to provide services and education to students with asthma and prepare staff to handle their illnesses. Although Idaho's middle and high schools have ensured that the majority of asthmatic students have immediate access to their medication while at school, many have not enacted a number of recommended asthma management activities (Figure VII-10). Notably, only about half of secondary schools track students with asthma, compared to over 80 percent of the Nation's schools. Similarly, only a minority of Idaho's schools have asthma action plans on file either with the school nurse or school office. These plans provide critical information about each asthmatic student's prescribed treatment regime and provide instructions on how to handle asthma medical emergencies. Both Idaho and the nation have much work to do to ensure that schools follow up with asthmatic students that miss an excessive amount of school. And, as mentioned earlier, Idaho schools are much less likely than schools across the country to have an RN on staff that is available full time.



Source: Hayes et al., 2004

Lastly, asthma awareness and education efforts are relatively low both in Idaho and across the United States, although a smaller proportion of staff in Idaho's schools received asthma education.

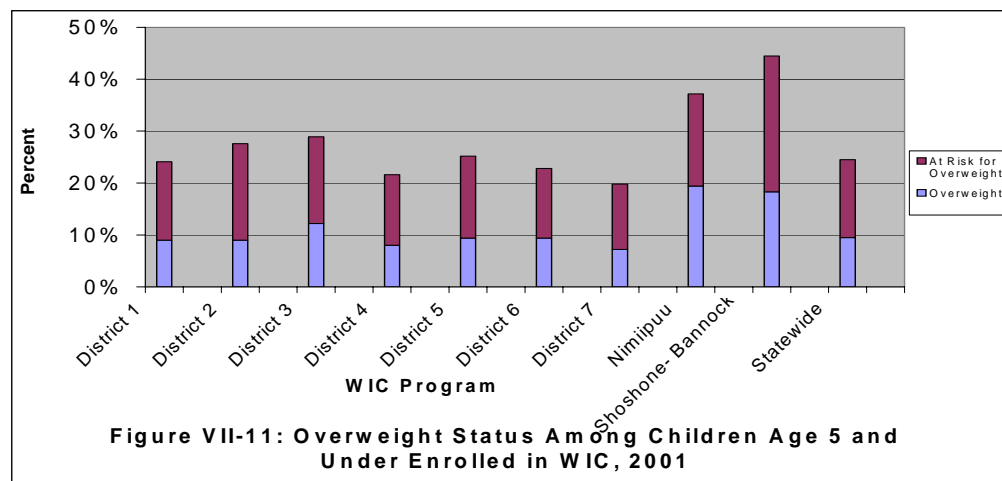
In 2002, Idaho Asthma Prevention and Control Project collaborate with Idaho's seven health district offices to conduct a statewide asthma needs assessment to enhance asthma management strategies. The assessment provided a set of recommendations based on participants' input at numerous community forums. This input will be used to establish a comprehensive statewide asthma management plan. Many recommendations specifically focused on developing protocols in school and child care settings. These included reducing exposure to indoor air triggers like environmental smoke in childcare facilities and ensuring that school staff maintain asthma action plans for all asthmatic students. The assessment also mentioned the school nurse shortage as a major impairment to adequate asthma management (Idaho Department of Health and Welfare, 2002).

### *iii) Weight Control and Obesity*

Obesity has increasingly become an important public health concern, particularly its rising prevalence among children and adolescents. The prevalence of obesity in children over the age of 5 has more than doubled since the late 1970s. Prevalence is measured by calculating one's BMI, measured as weight in kilograms per squared height in meters. An individual is defined as overweight if his or her BMI is between 25 and 29.9 and obese at 30 or greater. Currently, 30 percent of children ages 6-19 in the United States are overweight and about 15 percent are obese. The increasing trend toward weight gain has been attributed to a range of lifestyle and genetic factors, but the most likely include children consuming diets high in fat and calories but low in nutrients as well as a significant reduction in the amount of regular physical activity children have each day (American Obesity Association, 2004). Schools play an important role in the childhood obesity epidemic, both because they may increase its prevalence by serving students food of poor nutritional quality and reducing access to physical education and because schools are in a good position to reduce prevalence by implementing health promotion activities.

Healthy People 2010 has established a goal to decrease the proportion of children ages 6-19 who are overweight or obese to 5 percent (U.S. Department of Health and Human Services, 2000). There is no statewide survey that measures BMI among all young children below age 13 in Idaho. However, the Idaho WIC program does collect BMI data on WIC participants and can provide a rough approximation of the overweight status of children under 5 years old. These data are particularly important because the WIC Program can help reduce the risk of overweight with its nutrition education and vouchers for foods. It is important to note that the Idaho WIC Program does not use the term "obese" but instead defines overweight as a BMI at or above the 95<sup>th</sup> percentile on age-appropriate CDC/NCHS growth charts. The statewide prevalence of overweight among WIC children ages 0-5 has increased in recent years, from 6.9 percent in 1996

(Idaho Department of Health and Welfare, 1999) to 9.5 percent in 2001 (Idaho WIC Program, 2003). The most recent data available exclude very young children and indicate that 11.8 percent of children ages 2-5 were overweight in 2003 (Idaho WIC Program, 2005). National studies indicate that Native American children are often more likely to be overweight than the general population. Data from Idaho's WIC program indicates a similar trend among Native American children ages 0-5 in the Nimipuu and Shoshone-Bannock communities during 2001; a significantly higher proportion of Native American children were overweight or at risk of becoming overweight (Figure VII-11).

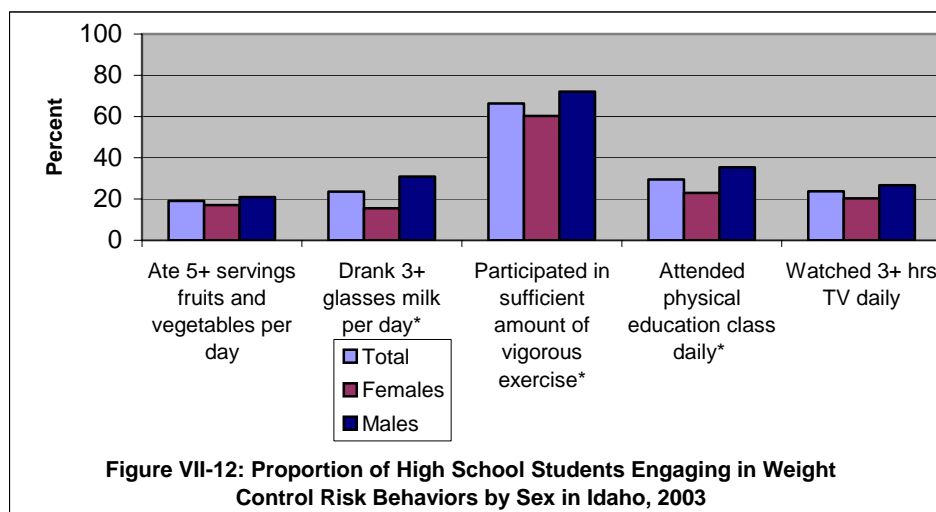


Note: At risk for overweight is defined as having a BMI at or above the 85<sup>th</sup> percentile on age-appropriate CDC/NCHS growth charts, while overweight is defined as having a BMI at or above the 95<sup>th</sup> percentile.  
Source: Idaho WIC Program, 2003

The Youth Risk Behavior Survey (YRBS) is the only statewide survey that measures overweight status, as well as the prevalence of behaviors that increase the risk of becoming overweight, among older children of high school age.

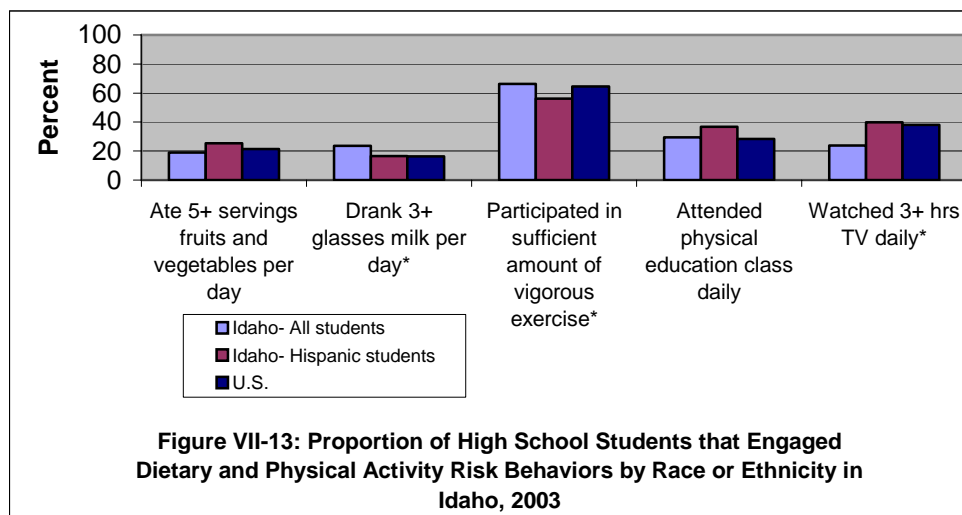
A sizeable proportion of Idaho's high school students engaged in dietary and physical activity risk behaviors during 2003. Less than a quarter of students met the CDC's recommendation that adolescents consume at least five servings of fruits and vegetables per day (National Center for Chronic Disease Prevention and Health Promotion, 2005a) (Figure VII-12). The CDC has not established similar specific recommendations for milk consumption but instead recommends that adolescents ages 14-18 consume at least 1,300 mg/day of calcium per day (National Center for Chronic Disease Prevention and Health Promotion, 2005b). Less than half of students tried to meet this recommendation by consuming three or more glasses of milk per day. Moreover, female students were significantly less likely than males to consume this level of milk, while Hispanic students were significantly less likely than all students to consume this level (Figure VII-13). A much smaller proportion of Idaho's students also met the Healthy People 2010 recommendations for physical activity; fewer than 85 percent participated in vigorous activity for at least 20 minutes 3 times a week and fewer than 50 percent attended daily physical education classes. Again, females were significantly less likely than males to meet these recommendations. Hispanic students were significantly less likely to participate in vigorous exercise than students overall. Idaho's students did meet the Healthy People 2010 recommendation that fewer than 25 percent of students watch 3 or more hours of television a day and were much less likely to

engage in this risk behavior than all students across the United State. However, Hispanic students did not meet this recommendation and were significantly more likely than all students in Idaho to watch excessive amounts of television.



\*Indicates a significant difference between female and male students

Source: National Center for Chronic Disease Prevention and Health Promotion, 2004



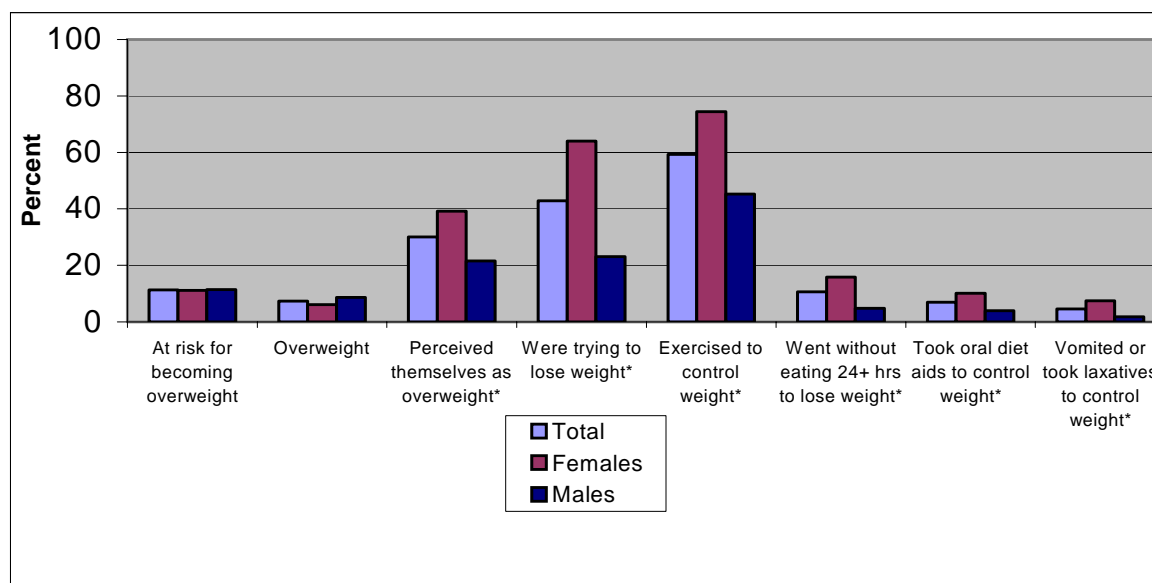
\*Indicates a significant difference between Hispanic students and students of all races/ethnicities in Idaho

Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

A total of 7.4 percent of Idaho's high school students were overweight in 2003, which is higher than the Healthy People 2010 goal to reduce this proportion to 5 percent (Figure VII-14). It is important to note that BMI was calculated using self-reported height and weight. Studies have found that adolescents may significantly underestimate their weight by as much as 20 percent (Brenner et al., 2004). Such underestimation may in turn underestimate BMI calculations among this population. There were no significant differences on either the proportion of students that

were overweight or at risk of becoming overweight between sexes. However, females were significantly more likely than males to perceive themselves as being overweight. Females were also significantly more likely than males to employ a variety of weight control measures. Behaviors such as excessive exercise, bingeing and purging, and starving oneself are potential warning signs of a distorted body image and a preoccupation with food that may be associated with eating disorders such as anorexia nervosa and bulimia. Females are typically more likely to develop such disorders; as many as 10 percent of American females are believed to suffer from an eating disorder (American Academy of Child & Adolescent Psychiatry, 2004). Eating disorders pose a significant threat to adolescent health, as they can lead to severe dehydration, hormonal imbalance, mineral depletion, and, in rare cases, death.

In addition, more than twice as many Hispanic students were determined to be overweight compared to all students combined: 16.7 percent compared to 7.4 percent, respectively (Figure VII-15). These data are representative of a growing national trend. From 1986 to 1998, obesity among Hispanic children increased by more than 120 percent, compared to just 50 percent among white children (Georgetown University Center on an Aging Society, 2002). Despite this disproportionately high prevalence of overweight, Hispanic students were no more likely than all students to perceive themselves as being overweight or to engage in any of the surveyed weight control measures. In national studies, students that perceive themselves to be overweight or at risk of being overweight have been significantly more likely to undertake weight control practices than students that perceive themselves as either normal weight or underweight (Brenner et al., 2004).

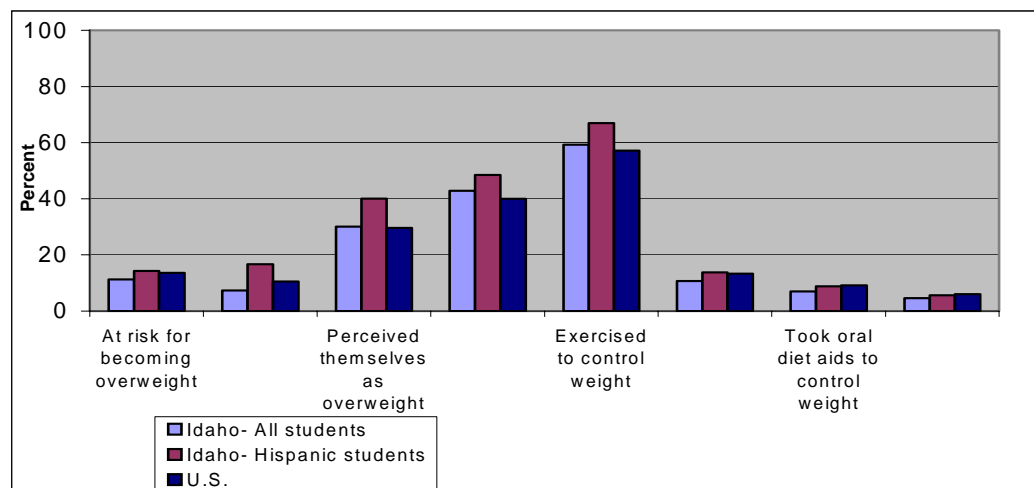


**Figure VII-14: Proportion of High School Students that Engaged in Weight Control Risk Behaviors by Sex in Idaho, 2003**

\*Indicates a significant difference between female and male students

Source: National Center for Chronic Disease Prevention and Health Promotion, 2004





**Figure VII-15: Proportion of High School Students that Engaged in Weight Control Risk Behaviors by Race or Ethnicity in Idaho, 2003**

\*Indicates a significant difference between Hispanic students and students of all races/ethnicities in Idaho

Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

#### *iv) Diabetes and Hypertension*

The growing prevalence of overweight and obesity among children has been associated with the development of a number of other chronic diseases in childhood including hypertension and diabetes (Dietz, 1998). Although there is currently no nationwide assessment tool available to monitor trends in childhood diabetes, there has been a substantial increase in clinical reports of new childhood diabetes diagnoses. Moreover, the American Academy of Pediatric has documented a significant increase in the proportion of new cases that are Type II diabetes. Type II diabetes has been traditionally referred to as adult-onset diabetes, as it typically does not develop until adults reach middle age. In 1990, fewer than 4 percent of new diagnoses of diabetes in children were Type II. By 2000, this proportion had increased to 30-50 percent newly diagnosed cases among children (Rocchini, 2002). Native Americans are at particularly high risk of diabetes: they are over 2.5 times more likely to develop diabetes as non-Hispanic Whites of similar age.

Similar to the United States, Idaho has yet to evaluate statewide trends in diabetes prevalence among children. The only available statewide diabetes data for children under age 18 are mortality rates due to diabetes, which are a poor measure for children since the disease usually does not become fatal until much later in life. The Idaho Diabetes Prevention and Control Project (IDPCP), although very effective at improving prevention and disease management efforts among adults aged 18 years and older since its 1994 inception, has not significantly focused on children and adolescents. In fact, none of the recent IDPCP or IDHW publications specifically targets children in surveillance and intervention plans. This deficiency is potentially disconcerting in light of initial signs that the prevalence of childhood Type II diabetes is increasing in Idaho. The School Nurse Organization of Idaho (SNOI) indicated in an interview that their nurses have seen a growing number of children diagnosed with diabetes. SNOI has since requested funding to provide at least 0.4 equivalents of a person to provide a “floating RN” to help with diabetes management in schools.

An increasing number of children and adolescents are also at risk for developing hypertension. Between 1988-1994 and 1999-2000, systolic blood pressure increased 1.4 mm Hg and diastolic blood pressure increased 3.3 mm Hg among the nation's 8- to 17-year-olds (NHLBI Communications Office, 2004). These significantly high increases have led to the creation of new clinical practice guidelines that now include a prehypertension category. Prehypertension includes children with a systolic or diastolic pressure at and above the 90<sup>th</sup> percentile and up to the 95<sup>th</sup> percentile. Although cardiovascular diseases continue to be the leading cause of death among adults, there have been few efforts to begin primary prevention efforts during childhood and adolescence. As one of the most common preventable diseases, early intervention strategies could greatly reduce blood pressure measurements of children at risk of developing hypertension later in life.

#### **d. Oral Health**

Diseases of the mouth now account for the most common chronic childhood illnesses; tooth decay is five times more frequent than even pediatric asthma (Idaho Oral Health Program, 2001). Poor oral health contributes to sleep discomfort, difficulty eating, the ability to focus while in school (American Dental Association, 2004), and school absenteeism (Idaho Oral Health Summit, 2001). Fortunately, oral health presents one of the greatest opportunities to improve childhood health outcomes significantly with the advent of highly effective disease prevention strategies, such as public water fluoridation and subsidized dental sealant programs (Oral Health America, 2004).

Idaho has one of the most comprehensive State oral health data surveillance tools in the country for young children, the annual Idaho State Smile Survey (Oral Health Care America, 2004). The survey tracks the prevalence of oral health disease among elementary school children as well as the types of treatment they need and receive. The oral health diseases and treatments emphasized by Healthy People 2010 that also correspond to the most recent Idaho State Smile Survey in 2001 are presented in Table VII-3. Out of the four major oral health measures included in the survey, Idaho has met only one Healthy People 2010 oral health objective for young children; over half of third-graders did receive dental sealants in 2001. Idaho failed to meet all other Healthy People 2010 objectives across all grade levels. A large majority, 66 percent, of Idaho's students experienced dental caries by the 3<sup>rd</sup> grade. Moreover, over a quarter of third-graders' tooth decay went untreated, and only about a quarter received routine preventive services. Time trend data are available for only two measures.

**Table VII-3: Comparison of Oral Health Measures from the 2001 Idaho State Smile Survey to Healthy People 2010 Objectives**

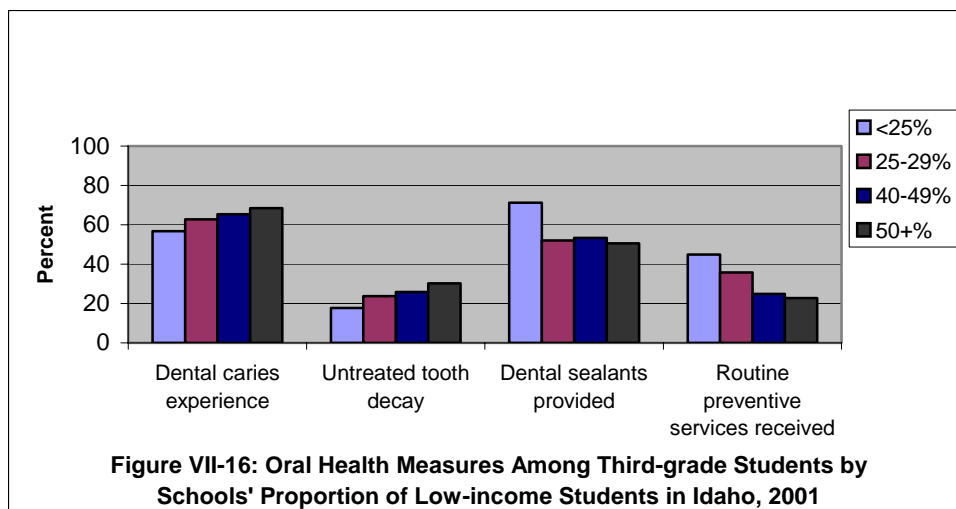
Oral Health Measure	Grade	Proportion of Idaho Students	Healthy People 2010 Target Proportion of Students
Dental caries experience	K *	46.4%	11%
	2**	62.1%	42%
	3**	65.9%	
Untreated tooth decay	K	28.1%	9%
	2	27.9%	21%
	3	27.3%	
Dental sealants received	2	38.0%	50%
	3	53.6%	
Routine preventive services received	K	42.3%	57%
	2	22.7%	
	3	27.2%	

\*All measures among kindergarteners refer to primary teeth only.

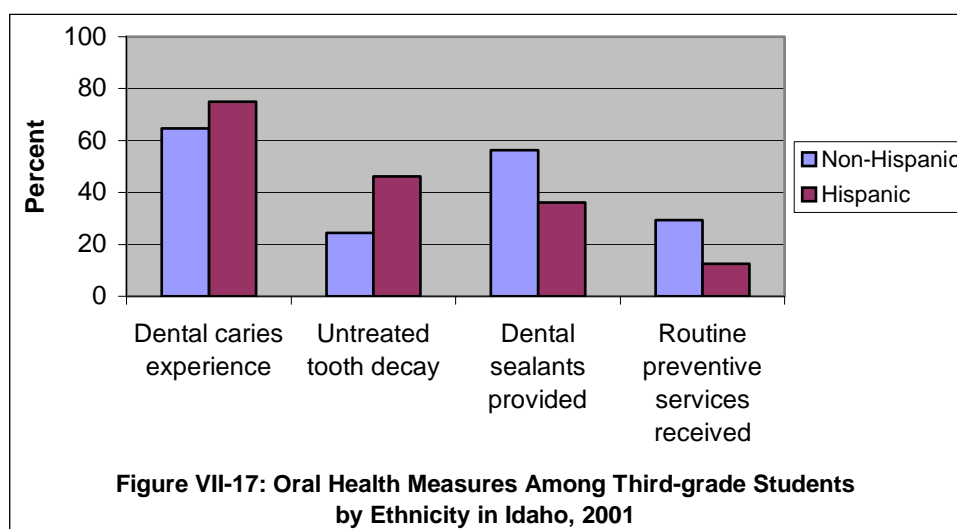
\*\*All measures among second- and third-graders refer to both primary and permanent teeth.

Sources: Idaho data is from the Idaho Oral Health Program (2003) and HP2010 objectives are from the U.S. Department of Health and Human Services (2000)

There were also some important disparities in young children's access to oral services. Schools with the greatest proportion of low-income third-graders, as determined by participation in the National School Lunch Program, had a much greater proportion of students that experienced dental caries and suffered from untreated tooth decay (Figure VII-16). Low-income third-graders also had a smaller proportion of students that received either dental sealants or routine preventive services. These same trends were observed among Hispanic third-graders compared to non-Hispanics (Figure VII-17). Hispanic third-graders had a much greater need for oral health services, but were much less likely to receive them. Similar disparities based on school income and race or ethnicity were observed among second-grade students as well (Idaho Oral Health Program, 2003). Although the Smile Survey did identify Native American 3<sup>rd</sup>-graders, only 22 Native American students were sampled. This small sample size does not permit analysis of this racial group. National data indicates that as many as 80 percent of Native American children ages 2-5 suffer from tooth decay, a proportion nearly twice as high as the general population in that age range (Friends Committee on National Legislation, 2004).



Source: 2001 Idaho State Smile Survey (Idaho Oral Health Program, 2003)



Source: 2001 Idaho State Smile Survey (Idaho Oral Health Program, 2003)

No statewide survey comparable to the Idaho State Smile Survey exists for older children, particularly adolescents. It is therefore not possible to measure Idaho's progress in meeting Healthy People 2010 objectives for adolescents. These objectives include: 1) reduce the proportion of 15-year-olds with dental caries to 51 percent, 2) reduce the proportion of 15-year-olds with untreated tooth decay to 15 percent, 3) increase the proportion of 14-year-olds with dental sealants to 50 percent, and 4) increase the proportion of all adolescents who receive any preventive dental service during the year to 57 percent (U.S. Department of Health and Human Services, 200).

Healthy People 2010 also recommends increasing the proportion of persons over age 2 that use the oral health care systems each year to 56 percent. Access to oral health care services is partially determined by dental insurance status, which significantly reduces out-of-pocket costs.

Idaho, however, does not routinely collect data regarding the proportion of children with dental insurance. If recent trends among adults are any indication, it is likely that many children may indeed lack dental insurance. Nearly 45 percent of adults over age 18 had no dental insurance, and 34 percent had no dental visits in the past year during 2003 (Idaho Department of Health and Welfare, 2003b).

A number of children, especially those from low-income families, obtain preventive oral health services from IDHW's Oral Health Program. The Program targets children ages 0-12 by offering several types of services administered through district health departments. The School Fluoride Mouthrinse Program serves the greatest number of children: 33,276 in 2004 (National Center for Chronic Disease Prevention and Health Promotion, 2005c). IDHW conducted a cost savings analysis and determined that the Mouthrinse Program prevented nearly 17,000 cavities in FY2003 (Idaho Oral Health Program, 2004). They also found that this service would save the State nearly \$700,000, assuming all restorative treatments were from Medicaid providers, or nearly \$1.4 million, assuming such treatments were from private providers. The Early Childhood Caries Prevention Project targets high-risk individuals enrolled in WIC, Head Start, and Summer Migrant school programs. In 2004, this program served 10,735 mothers, children, and others by offering oral screening, health education, and fluoride varnish application. The School Dental Sealant Project served 343 2<sup>nd</sup>- and 3<sup>rd</sup>-graders in 2004. Lastly, the Oral Health Program provided 15,421 students, parents, and community members with oral health education and health promotion activities (ID Oral Health Program, 2005).

Another important aspect of oral health programs is ensuring access to dental care providers. Parents that responded to the Family Health Survey indicated that finding a dentist for their children was among the most difficult services to access. Nearly half (48.7 percent) of parents of children ages 1-12 indicated they needed help finding a dentist. Of these 242 parents, 6.2 percent looked but could not find this help, and another 5.2 percent were able to find help but did not consider it useful.

In 2001, the Idaho Oral Health Summit was held to address oral health issues among children and adults. This Summit and the subsequent planning sessions led to the creation of a State oral health plan for 2002-2005. The plan established six main goals to secure increased funding for oral health and to improve access to services. The goal to strengthen the dental public health infrastructure will likely have a major impact on children's oral health outcomes. Specifically, the plan seeks to:

- Provide a full-time dental hygienist in each health district
- Integrate oral health into primary care
- Establish fully funded dental public health plans in each health district
- Increase salaries of public health dental hygienists to a level comparable to those in the private sector
- Establish a State Dental Director to oversee dental public health and Medicaid oral health (Idaho Oral Health Program, 2002).

## **e. Mental Health**

It is estimated that nearly 20 percent of all children in the United States have a diagnosable mental, emotional, or behavioral disorder. In addition, about 10 percent of all children in the Nation have a serious emotional disturbance (SED) that severely disrupts daily functioning in various settings. Although many disorders are in part due to genetics and chemical imbalances, they may also result from traumatic experiences, such as being the victim of child abuse, the daily stress of chronic poverty, and the loss of important relationships. The most common childhood mental health disorders relate to anxiety, conduct, depression, and learning. Children diagnosed with a mental health problem should receive mental health services immediately to prevent adverse outcomes such as poor school performance, truancy, and suicide (Substance Abuse and Mental Health Services Administration, 2003).

Many of the CMHCs in Idaho have been impacted by the 1980 Jeff D. Federal Class Action Lawsuit against the State of Idaho. The Lawsuit charged that many of Idaho's services for children with SED were limited to less effective institutionalized services, such as State mental hospitals, as opposed to more community-based services. The Lawsuit lingered in the judicial system for a number of years, but increasing pressure from the court to address the complaint prompted IDHW to conduct a needs assessment of children ages 0-21 in 1998. The needs assessment defined SED as a diagnosable mental illness that significantly impairs functioning and is expected to last an extended period of time. About 4 percent of the 0- to 21-year-olds, or nearly 19,000, in Idaho were found to meet these criteria for SED. The assessment also projected that 40 percent of children with SED, or about 7,500, have more serious disorders that will require publicly funded services at some point during the next year (Lourie and Davis, 1999).

Key findings from the 1998 Children with SED Assessment:

- Medicaid serves the majority of children with SED—nearly 2,300 in 1998—but covers the least intensive services; less than \$250 per child was spent on children's mental health services.
- IDHW's Child and Family Services operates the Children's Mental Health Program (CMHP), which provides ongoing and emergency mental health services, such as care coordination through private agencies or Psychosocial Rehabilitative Services (PSR), for children and adolescents with a qualified SED:
  - IDHW served 1,200 children with SED in 1998 at the cost of \$8.1 million.
  - IDWH services in 1998 tended to be of a low level and relatively short duration.
  - The program did not take on as many new children with SED as expected.
- Idaho Department of Education's Special Education Program spent \$420,000 to serve about 600 children with SED during the 1996-1997 school year, representing just 2.4 percent of the total Special Education enrollment; the true number of children with SED may have been underreported by school officials because of the difficulty in finding services and resources for children identified with serious needs.

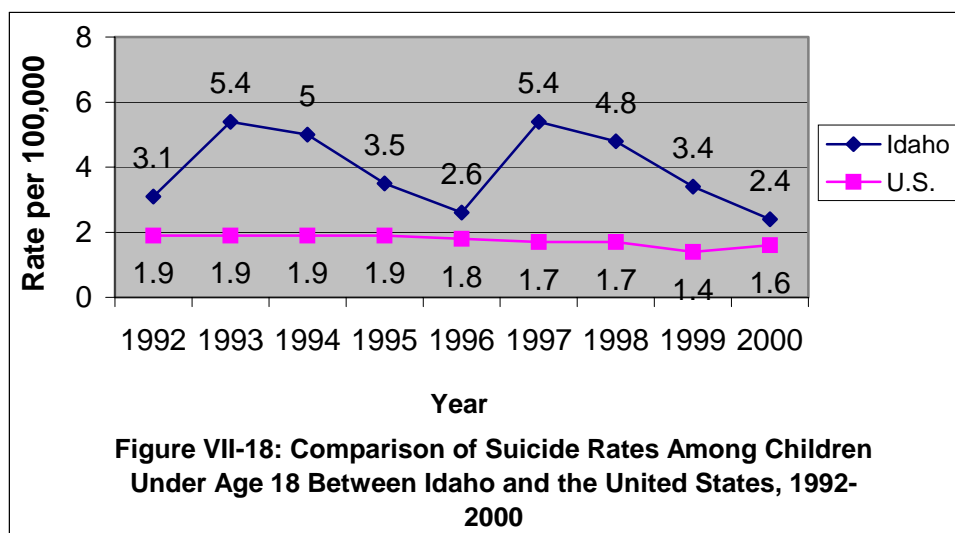
- The Idaho Department of Juvenile Corrections (IDJC) spent nearly as much money on children's mental health services as Medicaid—about \$10,000,000—but served only 200 children with SED; IDJC offers the most costly types of treatment, such as therapeutic group homes and hospital services (Lourie and Davis, 1999).

Services should provide families of children with SED adequate choices among treatment options, with the capacity to adjust services to meet their changing needs. In addition, case management and family support services are essential to helping families navigate and learn about all available mental health services that might be of benefit (Lourie and Davis, 1999). The authors also noted that intensive treatments, such as inpatient hospital services, are often ineffective for many children with SED, especially those in the juvenile justice population. The assessment recommended that Idaho work to minimize such ineffective institutional care and instead promote more promising community-based services.

Following completion of the assessment, the State has developed an intra-agency infrastructure to coordinate services, the Idaho Council on Children's Mental Health (ICCMH), and has begun to implement other recommendations from the assessment. Some recent accomplishments include the following:

- The proportion of children with SED that received publicly funded mental health insurance increased from 75 percent in 2002 to 85 percent in 2003 (Idaho Department of Health and Welfare, 2003b)
- The number of total children served by the CMHP nearly doubled during 1998 to 2003, from 2,349 (Lourie and Davies, 1999) to 4,317 (Idaho Council on Children's Mental Health, 2004).
- Regional and local councils have been established to deliver coordinated, community-based services, which served 110 children in 2003 (Idaho Department of Health and Welfare, 2003b).
- The Idaho Department of Education increased the number of children with SED enrolled in the special education program to nearly 1,200 in the 2003-2004 school year, representing about 6 percent of the special education population (Idaho Department of Education, 2004a). Idaho is now much closer to matching the national trend of 8.5 percent of all special-education students served diagnosed with SED (Lourie and Davis, 1999).
- The Idaho Federation of Families for Children's Mental Health, a parent-run advocacy organization, has been established to help children and families with mental, emotional, and behavioral disorders to access community-based services and to establish a system of care. Children do not need to meet any eligibility requirements and can receive free services, such as parent and sibling support groups, referrals to community-based services, and parent education on a range of topics (Idaho Children's Mental Health Program, 2001).

Despite the recent expansions in service capacity, many children with SED remain underserved. The number of counties with a mental health professional shortage has grown since 2001; all children in Idaho now reside in such counties (Idaho Department of Health and Welfare, 2004c). In addition, childhood suicide remains a significant area of unmet need. Historical trends indicate that the Intermountain West Region of the United States has consistently had a higher suicide rate than either the Eastern or Midwestern Regions for over a decade. Idaho's child suicide rate has been as high as three times the national rate in recent years (Figure VII-18). Much of this increased risk has been attributed to both the declining economic well-being of rural areas, leading to social instability within families, and the lack of an adequate child mental health care system (Idaho Department of Health and Welfare, 2004b).

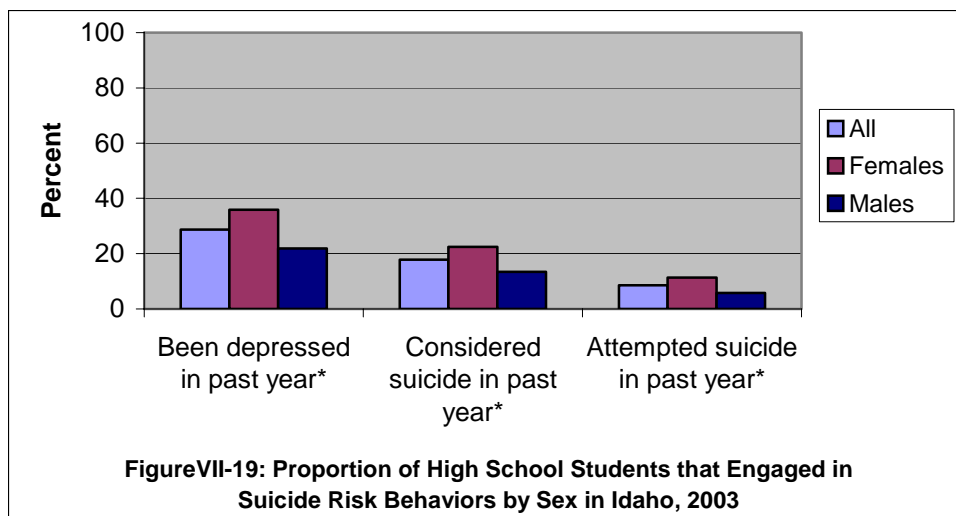


Source: Idaho Child Mortality Review Team, 2003

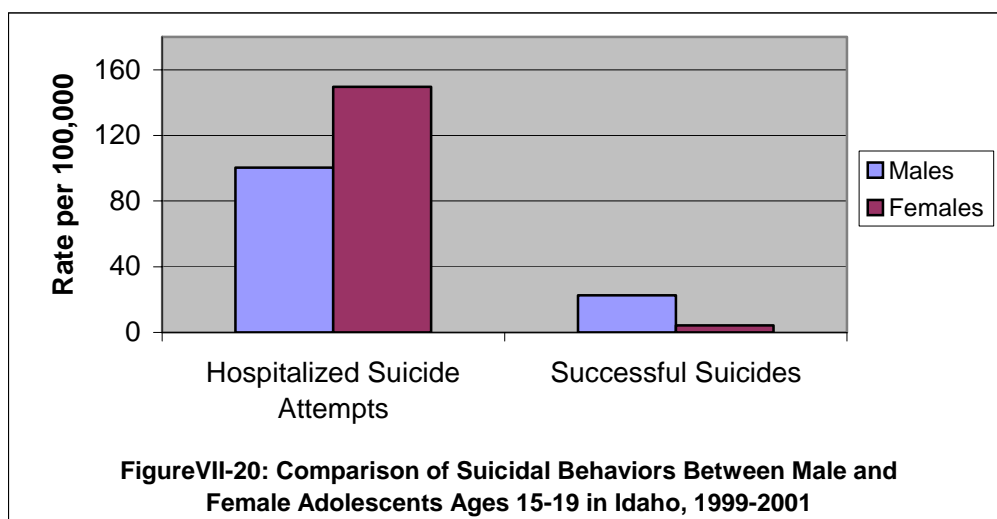
One of the most commonly measured precursors of suicidal thoughts is the experience of depression, defined by a 2-week or longer change in emotion, motivation, physical well-being, and thoughts (Olbrich, 2002). During 2003, nearly a third of high school students indicated that they experienced depression in the past year, with females at a significantly higher risk than males (Figure VII-19). A much smaller proportion of students, however, actually had thoughts of suicide.

The percentage of high school students reporting suicidal thoughts, 18 percent, and unsuccessful suicide attempts, 2.7 percent, were similar to national averages in 2003 and did not significantly change from 2001 (National Center for Chronic Disease Prevention and Health Promotion, 2004). Both Idaho and the nation must work to reach the Healthy People 2010 target to reduce suicide attempts to just 1 percent among 15- to 19-year-olds. It is also important to note the behavioral differences in suicide risk behaviors between male and female adolescents. A significantly higher proportion of females than males indicated they had had suicidal thoughts and attempted suicide in the past year in 2003. Following national trends, female adolescents in Idaho were much more likely to attempt suicide while male adolescents were much more likely to complete suicide during 1999-2001 (Figure VII-20).





\*Significant difference between female and male students  
 Source: National Center for Chronic Disease Prevention and Health Promotion, 2004



Sources: Data on hospitalized suicide attempts is from the Suicide Prevention Resource Center (2004) and data on completed suicides is from Idaho Department of Health and Welfare (2004b)

Adolescents in Idaho and the United States have been equally likely to attempt suicide, but those in Idaho have been far more likely to commit suicide successfully. Idaho's adolescent suicide rate of 17.7 per 100,000 among 15- to 19-year-olds during 1999-2001 far exceeded the national rate of 8.0 per 100,000 (Suicide Prevention Resource Center, 2004). Across the Nation, suicide is the 3<sup>rd</sup> leading cause of death among 15- to 19-year-olds, but suicide was the 2<sup>nd</sup> leading cause of death for this age group in Idaho during 2002 (Idaho Department of Health and Welfare, 2004g). The suicide rate among Native American youth is even more astounding. Young Native American males 15-17 years old had the highest suicide rate of any population subgroup in Idaho, with 116 suicides per 100,000 during 1992-2001.

In November 2004, multiple State agencies, including IDHW and the Department of Education, developed a State plan to address the high suicide rate in Idaho, especially among adolescents

and Native Americans. The plan recommended creating a local community-based infrastructure to oversee the implementation of suicide prevention efforts as well as promote dissemination and use of best practices guidelines to professionals working with at-risk youth. To monitor better the progress in reducing the suicide rate, the plan also recommended developing a method of standardized data collection and performance measurement (Idaho Department of Health and Welfare, 2004b).

**2. *Children are cared for in environments that protect their health, promote their well-being, and ensure their safety.***

**a. Early Child Development**

The foundations of development and proper maturity are initially developed in the first few years of life. Therefore, it is critical to meet all the development needs of children to prevent poor health outcomes such as learning and developmental delays and poor social functioning. Children exhibiting such characteristics are more likely to end up in foster care and the juvenile justice system and have difficulty performing well in school. Quality child care and school readiness programs help promote children's social, cognitive, and emotional development (Idaho Kids Count, 2003).

**i) *Child Care***

Nearly half of all working families are unable to rely solely on family members and friends for child care and must arrange such care through private providers. Child care expenses can pose a significant economic burden on many families, ranging between \$4,000 and \$10,000 a year per child (Friedman, 2005). Parents that responded to the Family Survey indicated that child care concerns were indeed a major concern in Idaho. Nearly half (45.5 percent) of parents of children ages 1-12 indicated they needed help finding child care services. Of these 227 parents, 7.6 percent looked but could not find this help, and another 6.4 percent found help but did not consider it helpful.

The primary Federal child care program for low-income families, including TANF recipients, is administered through the Child Care and Development Fund (CCDF). This program provides subsidies for the care of typical children under age 13 and CSHCN incapable of self-care up to age 19 (Child Care Bureau, 2004b). In Idaho, CCDF subsidies are administered by the Idaho Child Care Program (ICCP). In 1999, ICCP served 7,560 children, representing 11 percent of all Idaho children eligible for this service (Child Welfare League, 2003). The number of children served has since increased to 9,413 in FY2004 (Idaho Child Care Program, 2004).

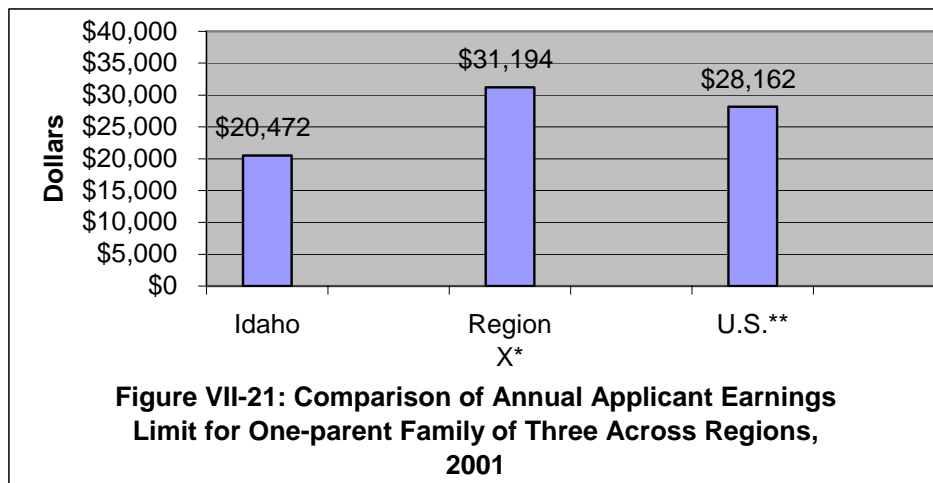
<b>Table VII-4.</b> <b>Comparison of the Number of Families Receiving CCDF Subsidies Between Idaho and Other Regions, 2000-2003</b>			
<b>Region</b>	<b>2000</b>	<b>2001</b>	<b>2003</b>
Idaho	4,800	5,600	4,400
Region X*	12,750	13,425	12,600
U.S.**	20,772	20,957	20,053

\*Represents averages of values for all Region X States

\*\*Represents averages of values for all 50 U.S. States

Source: National Center for Children in Poverty, 2005

Compared to other regions, ICCP's impact on filling the child care affordability gap has been relatively limited. Idaho has served a much smaller number of families in the past few years than other regions. During 2003, Region X served an average of three times as many families with CCDF subsidies, while the Nation as a whole served an average of five times as many families (Table VII-4). This is likely due in part to the much lower applicant annual earning limits in Idaho than other regions: only about \$20,000 for a 1-parent family of 3 (Figure VII-21). ICCP subsidies are therefore reserved for only the most destitute of families. However, many near-poor families whose income exceeds this amount may be struggling to afford child care costs and could also benefit from access to subsidies.

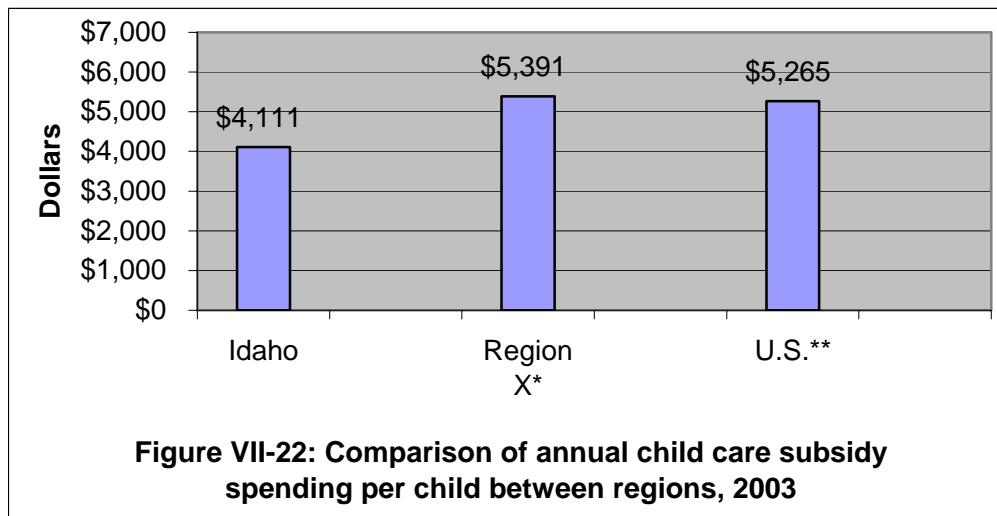


\*Represents averages of values for all Region X States

\*\*Represents averages of values for all 50 U.S. States

Source: National Center for Children in Poverty, 2005

Another important distinction of ICCP is that it is among the top 10 States with the lowest spending per child in the nation (National Center for Children in Poverty, 2004). ICCP's spending per child during 2001, \$3,313, was 22 percent lower than the Region X average and 44 percent lower than the national average (Figure VII-22). This lower spending level has likely limited the ICCP's ability to offer the full range of services common to many other States' child care programs. For example, nearly half of all States provide health screenings, meals, and family case workers or home visits to their subsidized early child care programs, while the ICCP offers none of these services to its young children (Mason, 2003). However, Idaho child care providers are required to ensure that all children in their care have up-to-date immunizations.



\*Represents averages of values for all Region X States

\*\*Represents averages of values for all 50 U.S. States

Source: National Center for Children in Poverty, 2004

Child care quality is of particular concern to parents who must entrust their children's safety to staff for a large part of the day. Factors such as inadequate training, relatively low wages, and a very high turnover rate among child care staff often contribute to low-quality care. State regulation and regular monitoring of child care staff and facilities can significantly improve the quality of care provided as well as improve children's health and development outcomes (Friedman, 2005). The ICCP has a relatively limited level of regulation. In 2001, 45 percent of ICCP children were served in legal, but unregulated child care settings, compared to just 27 percent of children nationwide. However, this proportion is actually on par with Region X settings; 41 percent of children in Region are in unregulated settings (Child Care Bureau, 2004b). Except for several cities with stricter regulations, child care providers in Idaho may care for up to six children without any kind of documentation. In addition, providers can also care for 7-12 children with just certification. These providers may apply for a license, but that decision is strictly voluntary. Only providers with 13 or more children are required to apply for a State license to operate, an important distinction given that only licensed settings are subject to regular inspection from the State. Other settings are not inspected until someone files a formal complaint to trigger an investigation (Mason, 2003).

The extent of staff requirements for child care providers are criminal background checks (Idaho Department of Health and Welfare, 2005d). Providers are not required to have preservice child care experience or a minimum level of education. Also, only licensed providers are required to obtain regular training, and even this requirement is limited to a total of 4 hours per year and does not include a child development component. To help remedy this deficiency, the IDHW collaborated with other child care stakeholders, including the Idaho Association for the Education of Young Children and the University of Idaho Center on Disabilities and Human Development, in 2000 to develop a quality training program (IdahoSTARS, 2004). The Idaho State Training and Registry System (IdahoSTARS) is a voluntary professional development system for all types of child care workers, including those in the school system and Head Start, that work with children ages 0-8. Some of the main goals project are collecting and maintaining data on providers, increasing access to and affordability of care, and establishing provider

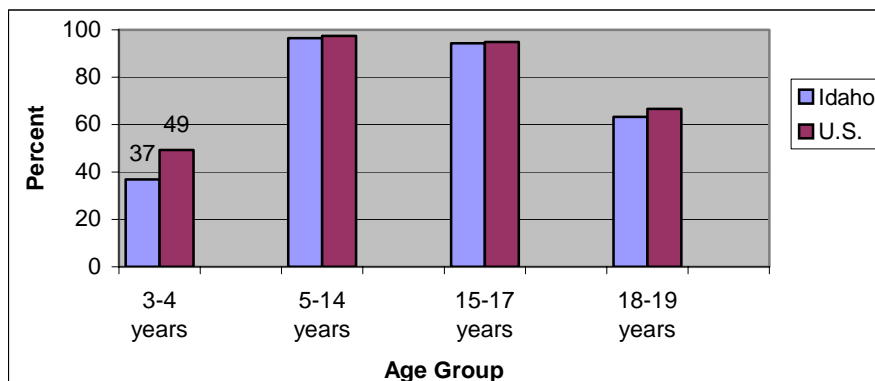
training standards and providing training opportunities. More broadly, Governor Kempthorne has also established several task forces, including the Idaho Child Care Program Advisory Panel, to address the possibility of stricter child care regulations and integrating child care services into an overall infrastructure for early childhood services. IDHW has also made injury and disease prevention a top priority in child care settings (Mason, 2003).

#### What did Parents Say?

Many parents in the focus groups indicated that child care was a very important issue for them, particularly finding quality providers with sufficient training. They expressed that it would be helpful if there were some means of acquiring information about the background and quality rating of each facility, such as a quality report card. Some who receive ICCP subsidies mentioned that some child care providers will take children enrolled in ICCP because the subsidies are too low and it takes too long for the providers to receive the payment. Hispanic parents were very concerned about the eligibility requirements for ICCP, indicating that active migrant workers are much more likely to qualify for subsidies than are low-income workers in other industries.

#### ii) Early Education

In terms of school enrollment, the majority of Idaho's students are enrolled in school similarly to the United States, but only 37 percent of 3- and 4-year-olds are enrolled compared to 49 percent nationally (Figure VII-23). This may in part be due to the lack of a State-funded preschool program in Idaho. Across the Nation, such programs served over 730,000 students in 2002-2003, or about 10 percent of the nation's 3- and 4-year-olds. Idaho is 1 of just 12 States that lack State-funded preschool programs. However, the State superintendent is considering pursuing a proposal for a comprehensive preschool program to the Idaho legislature within the next few years (Barnett et al., 2004). Another important public early education program is Early Head Start, which helps promote primary school readiness among low-income children.



**Figure VII-23: Comparison of School Enrollment Between Idaho and the United States, 2000**

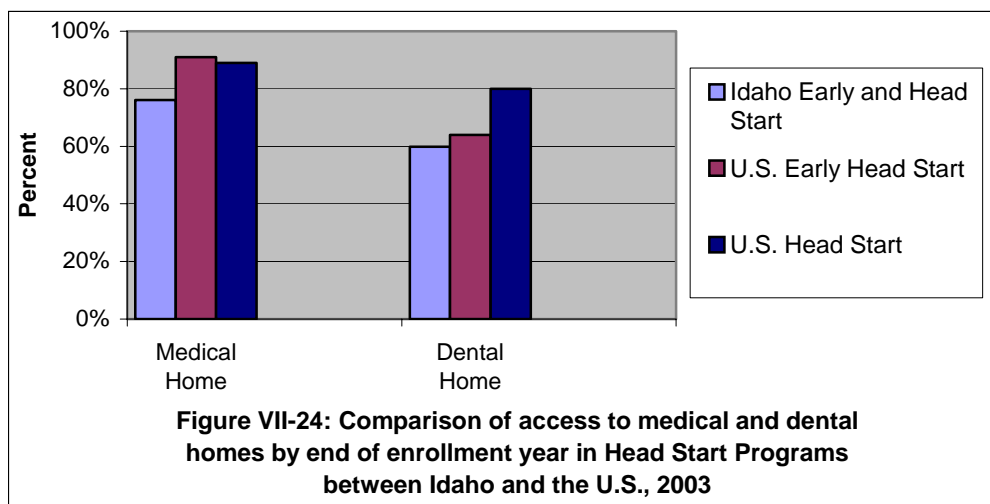
Source: U.S. Census Bureau, 2001

## Head Start Programs

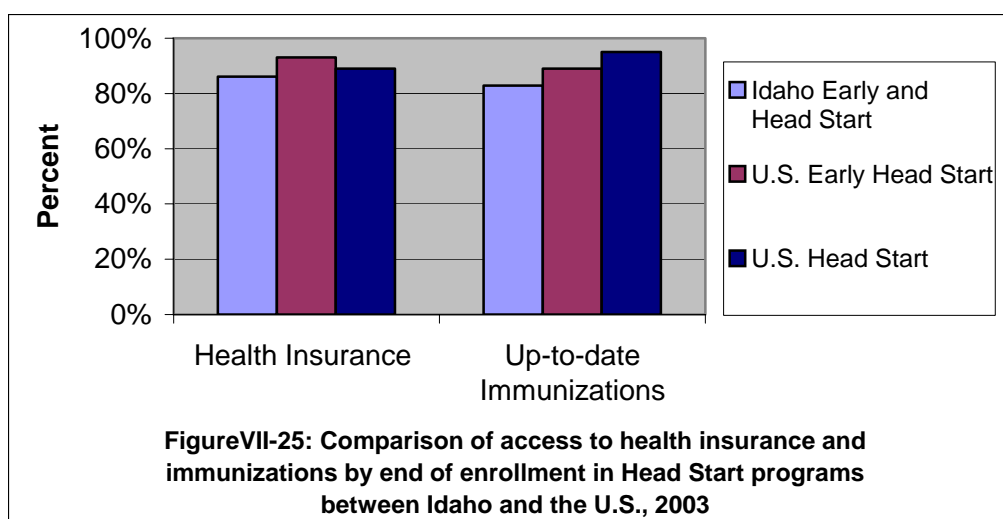
Since 1965, the Head Start program has also provided many low-income children ages 3-5 with child care, critical early education, and support services. The Early Head Start program, created in 1995, expanded these services to infants and toddlers from birth to age 2 and pregnant women. During the 2002-2003 program year, a slightly greater proportion of children were enrolled in Idaho's Early Head Start, 11 percent (Idaho Head Start Association, 2004), than the national average, 8 percent (Center for Law and Social Policy, 2004). Idaho's Head Start Programs have traditionally been funded solely by Federal and local funds and have not received State dollars. However in 1999, the Idaho Legislature designated an additional \$1.5 million to fund 188 additional Head Start enrollment slots for those receiving public assistance such as TAFI and Food Stamps (Barnett et al., 2004).

During the 2002-2003 program year, there were 13 Head Start programs throughout Idaho, including 1 program operated through the Idaho Migrant Council and 3 through tribal agencies. Total enrollment in all of Idaho's Head Start programs included 3,500 children and pregnant women. Despite the additional public assistance enrollment slots, this enrollment level served just 44 percent of Idaho's eligible 3- to 4-year-olds, the age group with the greatest enrollment (Idaho Head Start Association, 2003), compared to 54 percent of eligible 3- to 4-year-olds enrolled in Head Start programs across the Nation, based on FY2001 estimates (Gish, 2003). Lastly, five counties—Butte, Clark, Custer, Fremont, and Jefferson—do not currently offer any Head Start enrollment slots for eligible children. The 3- to 4-year-olds from these counties represented 6 percent of the unserved eligible population during 2002-2003 (Idaho Head Start Association, 2003).

Head Start programs provide a critical public health function by monitoring the health status of enrollees and helping them access needed medical and dental care (Center for Law and Social Policy, 2004). Unfortunately, fewer of Idaho's enrollees had such continuous sources of medical and dental care and received the required screenings than enrollees across the nation (Figure\_). Enrollees across the nation were slightly more likely to have health insurance than enrollees in Idaho by end of the enrollment year (Figure VII-25). Moreover, Idaho enrollees were also much less likely than the United States to be up to date on all age-appropriate immunizations. Despite these shortcomings, Idaho's programs did increase access to a range of primary health care related services between the beginning of enrollment and the end of the year. Over a quarter of enrollees, 28 percent, were initially uninsured, but this proportion later declined to just 12 percent. Similarly, 16 percent more children gained access to a medical home and 17 percent gained access to dental home (Idaho Head Start Association, 2003).



Sources: Idaho data is from the Idaho Head Start Association (2004) and U.S. data is from the Center for Law and Social Policy (2004)



Sources: Idaho data is from the Idaho Head Start Association (2004) and U.S. data is from the Center for Law and Social Policy (2004)

A comparable proportion of children were diagnosed with disabilities and received special services for their disabilities in both Idaho and the United States. No data could be located to compare mental health services between Idaho and the United States, but it is important to note that nearly 40 percent of enrollees in Idaho referred to mental health services did not actually receive these services (Table VII-5). The Head Start Program Performance Standards require that programs screen all children for developmental, sensory, and behavioral concerns (Center for Law and Social Policy, 2004), but Idaho's programs screened only about three-quarters of enrollees.

<b>Table VII-5. Selected Mental Health Service Characteristics of Children Enrolled in Idaho's Head Start Programs, 2003</b>	
<b>Mental Health Services Received</b>	<b>Proportion of Children that Received Services</b>
Mental health professional consulted with program staff about child's behavior and/or mental health	29.0%
Referral for mental health services outside the Head Start program	4.9%
Of those referred, proportion that received services during operating period	61.8%
Received screening for developmental, sensory and behavioral concerns	76.3%
Of those screened, proportion needing followup assessment	14.0%

Source: Idaho Head Start Association (2004)

#### **b. School-based Health Services**

Outside of hospitals and community clinics, many children also receive primary health care services from K-12 schools. Many schools perform basic screenings such as vision and hearing, monitor immunization records, assist students with chronic conditions in their treatment regimes, refer students to more intensive treatment services, and provide first-response emergency medical care. Proper coordination of services and regulations can help improve the quality and scope of school-based health services.

The Idaho Department of Education does not systematically collect data about the range of health services offered, health staff characteristics, or the number or type of students served (personal contact with Idaho Department of Education). However, the School Health Policies and Programs Study (SHPPS) provides some information on Idaho's school-based health services. SHPPS is a national survey that assesses trends in school health policies and programs across States. The 2000 SHPPS indicated that Idaho's K-12 schools do not have a State health services coordinator, compared to 88 percent of all States (Hayes et al., 2002), nor does it require schools or districts to designate a health services coordinator (National Association of School Boards of Education, 2005). The survey also indicated that Idaho does not require schools or districts to screen students for hearing, height and weight, oral health, vision, tuberculosis, or scoliosis (Hayes et al., 2002).

Many schools provide a range of health services, such as comprehensive physicals and lab tests, using school-based health centers. There are currently about 1,500 school-based health centers across the country, located in 43 states—all but Idaho, Hawaii, Montana, Nebraska, North Dakota, South Dakota and Wyoming (National Assembly on School-based Health Care, 2003).

School nurses provide some of the school-based health services offered to Idaho's students. It is estimated that about 10 percent of Idaho's schools currently have school nurses that administer



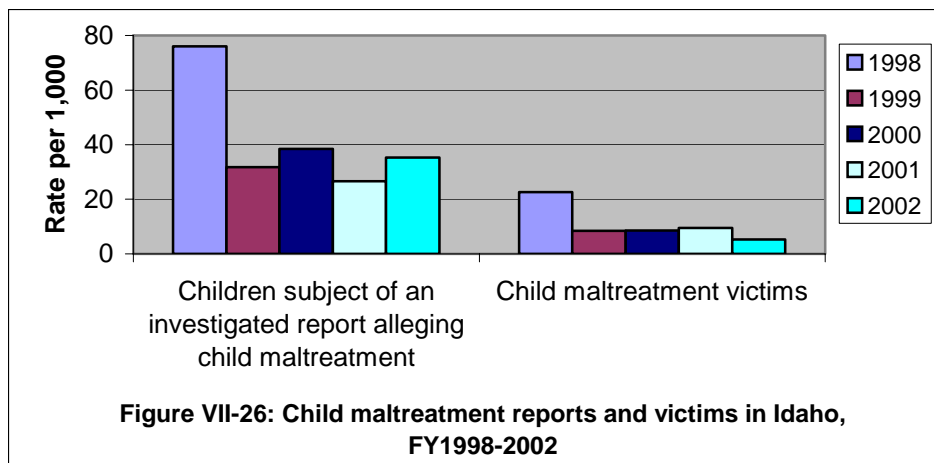
health services (Key Informant Interview with SNOI, 12/16/04). The nationally recommended nurse-to-student ratio is 1:750, which 53 percent of schools nationwide have (Hayes et al., 2002), 2000). However, it is estimated that the nurse-to-student ratio in Idaho is 1:950 (key-informant interview with SNOI, 12/16/04). School nurses are bound by strict regulations regarding administering of medicine under Idaho's Nurse Practice Act (key-informant interview with SNOI, 12/16/04) and are required to be licensed and certified (Hayes et al., 2002). Most school nurses in Idaho have just an LN, which is adequate for most health concerns. In the schools lacking a school nurse, any school staff can administer medication and emergency medicine, but they are not bound by the regulations in the Nurse Practice Act or required to have formal medical training. For more serious health concerns, schools and districts can contract with district health departments to fund a part-time RN. However, RNs are often available only to help care for CSHCN.

### **c. Child Maltreatment**

One of the most disturbing and all-too-common health risks that children face is maltreatment. There were over 980,000 maltreatment victims in 1997 across the United States and its territories. Nearly three-quarters of maltreatment perpetrators are parents, and another 10 percent are other relatives. Children that are victims of maltreatment are haunted by this experience throughout their lifetime. Victims commonly exhibit behavioral problems in school, develop substance abuse habits, engage in criminal activity, and may even grow up to abuse or neglect their own children (Idaho Kids Count, 2003). MCH systems play a critical role in identifying cases of abuse and neglect; about 60 percent of the substantiated or indicated reports of maltreatment were from legal, medical, education, and social service professionals (U.S. Department of Health and Human Services, 2000).

#### ***i) Maltreatment Prevalence***

Idaho has recently experienced a twofold decline in both the rate of child maltreatment reports filed and rates of confirmed maltreatment victims between 1998 and subsequent years during 1999-2002 (Figure VII-26). However, Idaho Kids Count (2003) attributes the higher rates of child abuse in the mid-1990s to methodological issues in counting and reporting incidents. Using the national standard method, they found that Idaho has consistently had a much lower-than-average rate of child maltreatment. In 2002, the child maltreatment rate in Idaho was 5.3 victims per 1,000, which is much lower than the Healthy People 2010 goal of 10.3 victims per 1,000 children under age 18.



Source: Idaho Kids Count, 2003

During 2002, Idaho children were much less likely to be victims of maltreatment than children across the United States. Despite this overall-lower occurrence of documented maltreatment, there have been important demographic changes over time that raise concern. A greater proportion of Idaho's maltreatment victims are increasingly younger in age; children under 5 years old comprised just 26 percent of the child victims in 1998 compared to nearly 40 percent in 2001 (Children's Bureau, 2004a). The maltreatment rate during 2002 was highest among children ages 0-3 (7.8 per 1,000) and steadily lower among older age groups. The proportion of child victims in each racial or ethnic category changed little between 1998-2001, with one notable exception: the proportion of Native American victims steadily increased from 1.5 percent in 1998 to 3.7 percent in 2001 (Children's Bureau, 2004a). During 2002, Native American children had the highest rate of victimization, 16.0 per 1,000, followed by African-Americans, 7.7 per 1,000 (Table VII-6).

<b>Table VII-6. General Demographics of Child Maltreatment Victims in Idaho and the United States, FY2002</b>		
<b>Demographics</b>	<b>Idaho Rate per 1,000</b>	<b>U.S. Rate per 1,000</b>
Total	5.3	17.3
<b>Sex:</b>		
Male	4.9	11.6
Female	5.6	13.6
<b>Age:</b>		
0-3 years	7.8	16.0
4-7 years	5.4	13.7
8-11 years	5.2	11.9
12-15 years	4.3	10.6
16-17 years	2.4	6.0

<b>Table VII-6. General Demographics of Child Maltreatment Victims in Idaho and the United States, FY2002</b>		
<b>Demographics</b>	<b>Idaho Rate per 1,000</b>	<b>U.S. Rate per 1,000</b>
<b>Race/ethnicity:</b>		
African American	7.7	20.2
American Indian/Alaska Native	16.0	21.7
White	4.7	10.7
Multiple Race	1.6	12.4
Hispanic, any race	6.3	9.5
<b>Types of maltreatment:</b>		
Physical Abuse	1.0	2.3
Neglect	3.5	7.2
Medical Neglect	0.1	0.2
Sexual Abuse	0.4	1.2
Psychological Maltreatment	0.04	0.8
Other/unknown	0.4	2.3

Source: Children's Bureau, 2004a

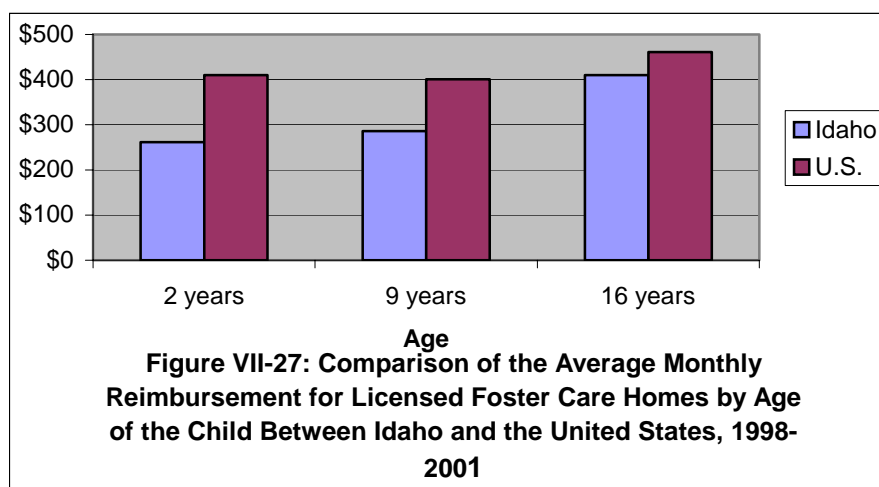
The most common type of abuse during 1998-2001 was neglect (nearly 45 percent), followed by physical abuse (nearly 20 percent). The proportion of victims experiencing sexual abuse steadily declined from 16 percent in 1998 to just 8 percent in 2001 (Children's Bureau, 2004a). During 2002, Idaho resembled the rest of the country, as children were much more likely to be victims of neglect than any other type of abuse. In addition, the child maltreatment fatality rate in Idaho, 0.54 deaths per 100,000, was lower than the national average rate of 1.98 deaths per 100,000. None of Idaho's child maltreatment fatalities occurred in foster care or families that had received prevention services or were reunited within the past 5 years (Children's Bureau, 2004a).

## *ii) Reviews of Child Protection Services*

Ideally, child protection systems should support three main goals: prevent abuse from happening, protect abused children from further maltreatment, and provide treatment for both maltreatment victims and abusers (Idaho Kids Count, 2003). To assess how well State child protection systems are meeting these goals, the ACF Children's Bureau annually conducts an Outcomes Report to evaluate performance on 13 measures that evaluate 7 national child welfare outcomes. The most recent report evaluates 2001 data. Overall, Idaho performed better than the national standard on a number of permanency measures in the Outcome Report. For example, fewer maltreatment victims in Idaho, 0.36 percent, experienced maltreatment while in foster care than the national standard of 0.57 percent or less (Children's Bureau, 2004a). Similarly, a much greater proportion, 89 percent, of foster children were reunified within 12 months than the national standard of 76.2 percent or more. However, Idaho's child protection services may need to improve performance in other key areas, such as ensuring that foster children do not re-enter the system. The national standard states that  $\leq 8.6$  percent of foster children should re-enter foster care within 12 months of discharge. Idaho previously met this goal during 1998-1999 but has

since exceeded this standard. In 2001, 12 percent of Idaho's foster children re-entered care within a year (Children's Bureau, 2004a).

Foster care provides temporary homes for child victims of maltreatment, and it serves a vital role in protecting these children from further harm. Nationally, there has been a substantial increase in the number of children entering State foster care systems, but there has been a decline in the number of licensed family foster homes to take in these children (Idaho Kids Count, 2003). In Idaho, all prospective families must become licensed, which involves passing a home health, fire, and safety inspection; meeting minimum income requirements; and attending various training sessions. The State provides dental and medical coverage to foster children and provides parents with a monthly reimbursement, based on children's ages and needs, to cover child care related costs (Idaho Department of Health and Welfare, 2005a). Idaho lags behind the nation with its relatively low monthly reimbursement, especially among younger children (Figure VII-27). This low reimbursement may deter some households from becoming a foster care home.



Source: Idaho Kids Count, 2003

In addition, the Children's Bureau also regularly conducts Child and Family Service Reviews (CFSR) using case reviews and interviews with stakeholders to assess States' conformity with six of the seven national outcomes (Children's Bureau, 2003). Idaho's most recent CFSR was conducted in FY2003 and includes Ada, Bannock, and Nez Perce counties to represent several regions. The results of this review found considerable regional variation; Ada County performed less well across a number of maltreatment outcomes than the other two counties. For example, only about half of cases in Ada County achieved substantial conformity on the measure regarding providing services to ensure children's safety and risk while in the home, compared to over 80 percent of cases in both Bannock and Nez Perce Counties (Children's Bureau, 2003).

On some CFSR measures, all reviewed counties performed poorly. Only 48 percent of all cases reviewed achieved substantial conformity in ensuring permanency and stability in children's living situations, which is much lower than the 90 percent required. Child protection systems ultimately seek to keep families intact and reunite children in out-of-home care with their families. However, this goal is not always feasible or in the best interests of all abused children. In these cases, it may be preferable to place such children in the long-term care of adoptive

parents. Through discussions with key Idaho officials, reviewers were able to identify important barriers to ensuring timely permanent placements. In some cases, the goal of reunification was maintained for too long when it was clear that adoption would be a much more feasible option. In others, the local agency did not take necessary steps to avoid delays in terminating parental rights and completing paperwork to accelerate adoptions (Children's Bureau, 2003).

IDHW has also conducted its own evaluation of child protection services across the State. During September through October 2004, the Regional Directors conducted focus groups with policymakers, parents, providers, and legal representatives to evaluate local child protection systems and identify gaps in services. Most of the complaints and service gaps related to mental health care services. In particular, focus group participants indicated that there was insufficient support for parents battling substance abuse. Mental health services are usually provided only to active drug users, not to those in recovery. When treatment was provided, many complained that it was of poor quality or too short in duration. Lastly, many parents lose their Medicaid eligibility when they have a child placed in protective custody. They therefore have to pay for treatment costs out of pockets, a large economic burden for most (Idaho Department of Health and Welfare, 2004h).

#### **d. Environmental Lead Exposure**

One of the greatest public health threats to children, especially very young children, is lead poisoning. Young children are most sensitive to lead exposure because of the underdevelopment of their organ systems. Children with elevated blood lead levels, or levels at or above 10 µg/dL, are at greater risk of experiencing neurotoxicity, which may impede intellectual functioning, behavioral development, and coordination. The removal of environmental sources of lead from paint, gasoline, food cans, and contaminated waste sites beginning in the 1970s has dramatically reduced the proportion of children with elevated blood lead levels (American Academy of Pediatrics, 1998). The CDC has also issued guidelines regarding local and statewide blood lead screening as a secondary prevention measure to reduce the impact and spread of lead exposure in communities. In 1991, the CDC's guidelines called for universal screening of all young children ages 9-12 months. Following concerns about the cost effectiveness of screening large numbers of children at relatively low risk of lead exposure, the CDC revised these guidelines in 1997 to limit screening to population groups most at risk for lead exposure (National Center for Environmental Health, 1997).

The IDHW has identified residents of the Coeur d'Alene River Basin as among the highest-risk groups in Idaho. The initial site in the area is the Bunker Hill Superfund Site, a 21-square-mile area commonly referred to as "the Box." The Box has been evaluated by health officials since 1974, and thousands of blood samples have been screened for lead levels. During the 1970s, as many as 75 percent of children ages 0-5 had elevated blood lead levels in the Box, and the mean blood lead level was as high as 70 µg/dL. Since then, the IDHW has collaborated with the Panhandle Health District and the Agency for Toxic Substances and Disease Registry (ATSDR) to implement public health education interventions and site cleanups. These measures have significantly reduced the elevated blood lead levels in children. In 2002, only 2 percent of the 259 children ages 0-6 screened had elevated blood lead levels, while the mean blood lead level was just 2.8 µg/dL (Agency for Toxic Substances and Disease Registry, 2003).

Children that live “outside of the Box” in the surrounding areas in the Coeur d’Alene River Basin have also been at higher risk of lead exposure. There were no regular child blood lead screenings of these areas from 1975-1995. The few child screenings that were conducted in the 1970s indicated that blood lead levels often exceeded 40 µg/dL (Agency for Toxic Substances and Disease Registry, 2003). In the summer of 1996, IDHW and the Panhandle Health District conducted the Coeur d’Alene River Basin Exposure Assessment, in which they screened 98 children under age 9 (Idaho Department of Health and Welfare, 1997). The Assessment found that 13.7 percent of all children screened had elevated blood levels (Agency for Toxic Substances and Disease Registry, 2003). IDHW have extended its interventions to areas outside the box, including annual blood lead screening for children. During 2002, just 4 percent of the 103 children ages 6 months to 9 years screened in these areas had elevated blood lead levels, and the mean blood lead level was 3.2 µg/dL (Agency for Toxic Substances and Disease Registry, 2003).

ATSDR has provided most of the funding for blood lead screenings in the Coeur d’Alene River Basin in an effort to reduce the proportion of children with elevated blood levels in the area to less than 5 percent. Results indicate that screened sites have met this goal for the past few years. Seemingly due to these stabilized blood lead levels, ATSDR has recently decided to cease funding this annual screening program (key-informant interview with IDHW Bureau of Community and Environmental Health, March 16, 2005). The number of residents that have been screened has substantially dropped since funding was cut. IDHW has not replaced this funding using their own resources but have instead focused on continuing public health education programs and cleanup efforts in the Coeur d’Alene River Basin. At the current pace of these efforts, blood lead screening levels in resident children should remain at their current low levels. The CDC’s 1997 guidelines also indicated that States should develop and implement a statewide blood lead screening plan.

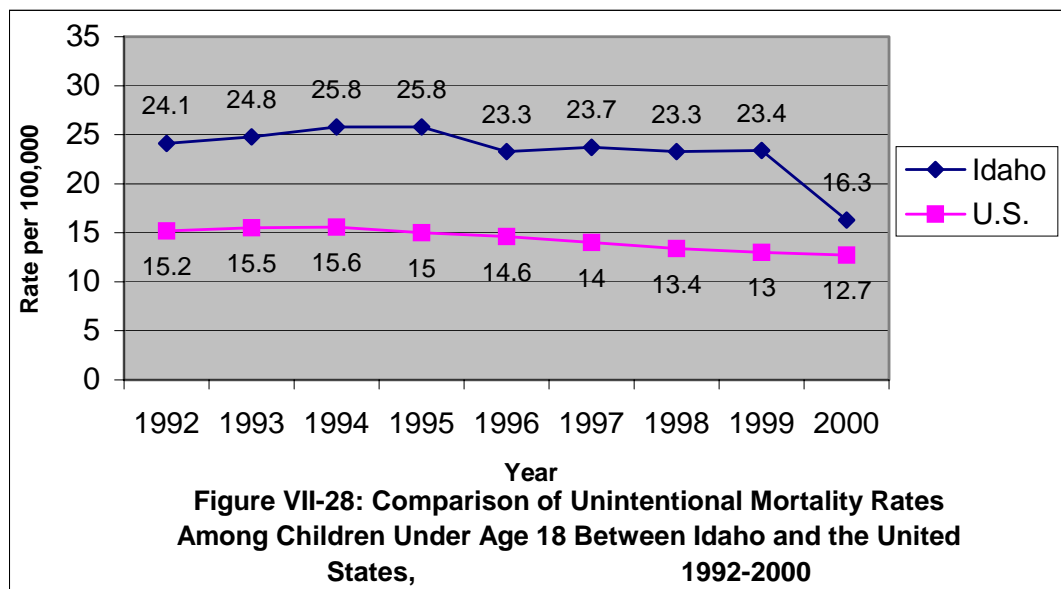
#### **e. Child Mortality**

Child mortality gained greater attention in Idaho as an important public health issue with the creation of Idaho’s Child Mortality Review Team in 1998. Their annual reports have provided invaluable information about the magnitude, type, and preventability of child deaths. The Team found that during 2000, the mortality rate across all age groups in children under age 18 was much lower than the national average (Idaho Child Mortality Review Team, 2003). Child mortality rates continued to compare favorably with national trends in 2002 among children and adolescents (Table VII-7). However, the child mortality rate exceeded the national rate for older adolescents ages 15-19. Idaho has also yet to meet any Healthy People 2010 child and adolescent mortality goals.

<b>Table VII-7.</b> <b>Comparison of All-cause Mortality Rates per 100,000 Children Age 19 and Under in Idaho and the United States to Healthy People 2010 Child and Adolescent Mortality Goals</b>			
<b>Age Group</b>	<b>Idaho, 2002</b>	<b>U.S., 2002</b>	<b>HP2010 Goal</b>
1-4 years	28.0	31.2	18.6
5-14 years	17.5	17.4	N/A
5-9 years	15.1	N/A	12.3
10-14 years	19.8	N/A	16.8
15-19	73.9	67.8	39.8

Sources: Idaho data is from the Idaho Department of Health and Welfare (2004g), U.S. data is from Kochanek et al. (2004), and HP2010 objectives are from U.S. Department of Health and Human Services (2000)

The leading cause of death for children of all ages in the United States is unintentional injury (U.S. Department of Health and Human Services, 2000). Since the early 1990s, children in Idaho have been at least 20 percent more likely to die of unintentional injuries than all American children (Figure VII-28). Motor vehicle crashes (MVC) are among the most frequent types of unintentional injury death. Nearly 20 percent of MVC deaths occur among 10- to 14-year-olds, and nearly 38 percent of MVC deaths occur among 15- to 19-year-olds nationwide (Centers for Disease Control and Prevention, 2004). In Idaho, children under 18 experienced 10.6 deaths per 100,000 to MVC in 2000, while the national rate was only 7.2 deaths per 100,000 (Idaho Child Mortality Review Team, 2003). In 2002, Idaho's childhood fatalities due to MVC accounted for 48 percent of deaths among 10- to 14-year-olds and 58 percent among 15- to 19-year-olds (Idaho Department of Health and Welfare, 2004g).



Source: Idaho Child Mortality Review Team, 2003

Intentional injuries comprised the next most common cause of death among children and adolescents. As previously mentioned, suicide was the second leading cause of death among children 10-19 years old, but rarely occurred in younger ages. Homicides were the third leading cause of death for children 1-4 years old and 15-19 years old.

**3. *Families have access to and use services that strengthen their parenting skills appropriately.***

**a. Parents as Teachers (PAT)**

PAT is a national voluntary program offered to pregnant women and mothers with young children up to age 3 that provides parenting education and support free of charge. Idaho currently has 34 PAT programs around the State that reached over 1,500 families and 2,200 children, with nearly 700 families on the waiting list during 2003. One of the main services includes home visits with child development specialists and developmental screenings. When screenings identify a potential developmental delay or physical problem, specialists refer parents for further assessment or treatment. Over 90 percent of parents typically follow through on referrals take their children for additional testing. PAT has also collaborated with the Infant-Toddler Program in some communities to help increase the number of developmental screenings completed. PAT also offered about 450 monthly parent support groups in 2003 and has helped families access numerous social services such as child care and mental health services (PAT, 2004).

**b. Head Start**

The Early Head Start and Head Start programs offer parenting education as part of its collection of family support services. During 2002-2003, 56 percent of families received parenting education, over 1,800 families (Idaho Head Start Association, 2004). Specifically, children receive weekly or monthly home visits to help parents reinforce the skills that children learned in classrooms as well as assistance in developing personal goals, accessing community resources and ensuring that children transition smoothly into the public school system (Idaho Head Start Association, 2003).

**c. Health care Facilities**

All seven CMHCs offer some form of parenting education on site, and nearly half refer parents outside to additional facilities offering parenting education (UDS, 2004). In addition, a number of parenting classes are offered by Idaho's hospitals, most for a small fee (Idaho CareLine, 2005).

**d. Other Community-based Organizations**

A number of community-based organizations offer parenting classes and other parenting support services. The Idaho CareLine will refer callers to many of these services in their communities. Classes may be geared just toward the parents or allow both parents and children to participate. Although some parenting services are offered free of charge, most charge at least a small fee. An



example of one of these organizations is Parents Encouraging Parents (PEP), which offers online parenting classes as well as discussions on topics such as stepparenting and joint custody (Idaho CareLine, 2005).

#### **What Did Parents Say:**

Some parents indicated that they had received formal parenting education while enrolled in WIC. The local WIC offices would hold classes on the days that mothers would come in to pick up their food vouchers. Others indicated they or their friends received parenting education through Family Service Alliance, which targets at-risk parents such as domestic violence victims. A couple knew of PAT as well, and one participant had received home visits from the organization. However, many women stated there were not enough parent classes and parent support groups in Idaho. They were especially interested in attending classes geared towards first-time parents and parents of CSHCN.

#### **4. *Adolescent children use ongoing health services appropriate to their stage of growth and development.***

As children grow into adolescence, they experience a range of new physical and emotional changes with the onset of puberty. During this time, youth become more sensitive to peer pressure while they also try to assert their own independence. Throughout this often confusing period, teens may be more likely to engage in a number of risk behaviors, including initiating sexual activity, experimenting with drugs and alcohol, and putting themselves at risk for injury. MCH systems can help youth make a smoother transition into adolescence by tailoring services to their unique risks and making them easily accessible.

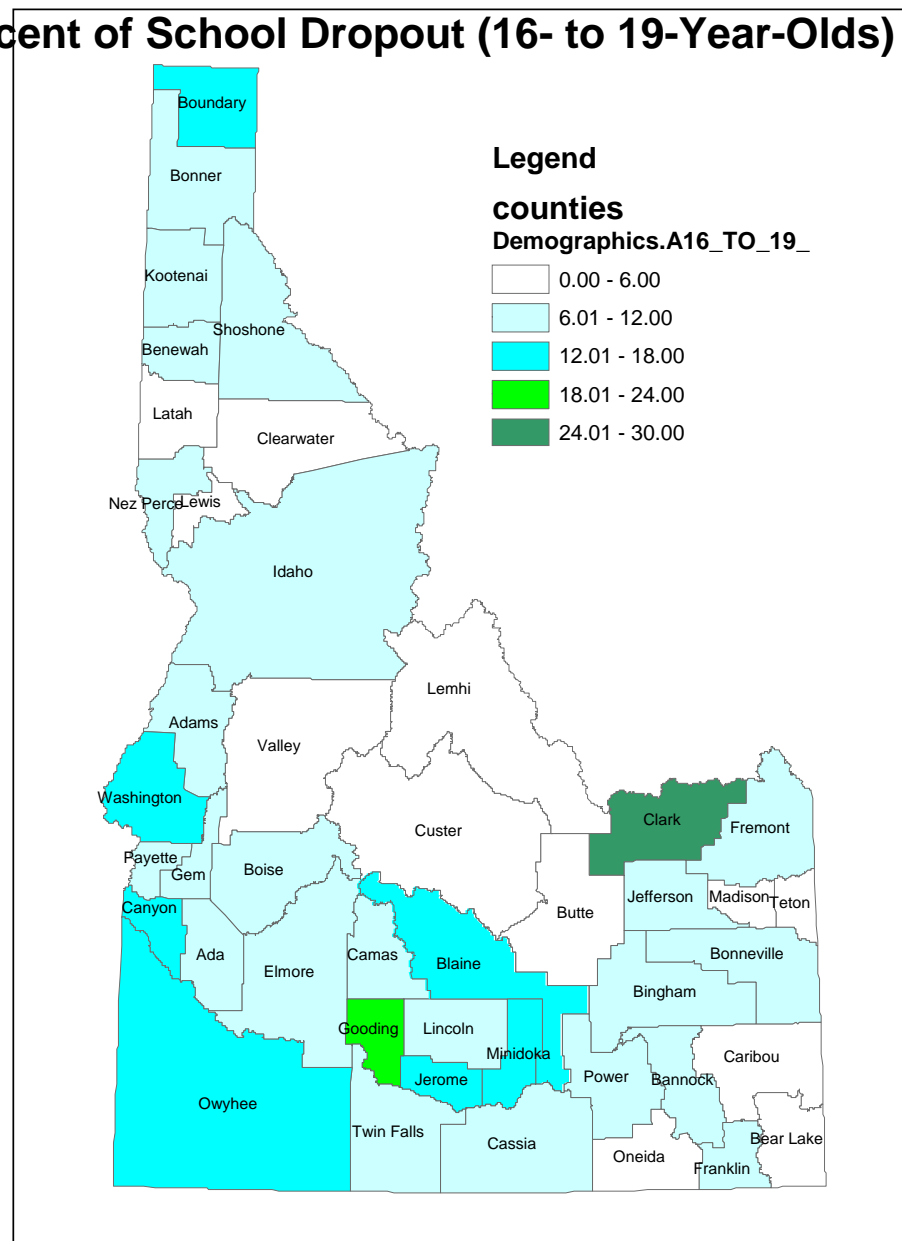
##### **a. High School Graduation**

Secondary schools play a vital role in helping youth mature and learn the basic skills necessary to progress successfully through puberty and can help promote success later in life as adults. For this reason, high school graduation has become an important health outcome for adolescents. Students that drop out of high school have a much higher likelihood of engaging in a number of risk behaviors, including substance use, delinquency, unintended pregnancy, and intentional injuries. Furthermore, adults with less than a high school diploma often have limited employment opportunities and are more likely to live in poverty (U.S. Department of Health and Human Services, 2000). Healthy People 2010 has established a goal to increase high school completion among young adults ages 18-24 to 90 percent. Idaho has not yet achieved this goal, as only 77.3 percent of young adults in this age range completed high school in 2000 (U.S. Census Bureau, 2001). However, this rate is higher than the national average, 74.7 percent.

Idaho ranks 12<sup>th</sup> in the nation for its relatively high rate of students graduating from high school, with only 5 percent dropping out during 1999-2000 (Idaho Kids Count, 2003). This represents a decline from the 7 percent dropout rate during 1995-1996 (Idaho Kids Count, 2003). There are some important regional differences within the State; Clark County had the highest dropout rate of over 24 percent (Figure VII-29). In addition, Boundary County and several Southeastern and South Central counties had particularly high dropout rates. Also, a much lower proportion of Idaho's adolescents go on to pursue higher education. In 1999, only about half of high school graduates attended a college or university, a much lower proportion than the national average of

64 percent (Idaho Kids Count, 2003). Research has long shown that individuals with only a high school diploma earn significantly lower salaries than those with postsecondary education degrees; those with a bachelor's degree earn 54 percent more annually. High school graduates also often have less stable jobs than those with higher degrees with a nearly three times higher unemployment rate.

## Percent of School Dropout (16- to 19-Year-Olds)



**Figure VII\_29: Map Displaying Distribution of High School Dropout Rates by County Among Idaho's Adolescents Ages 16-19 Years, 1999-2000**

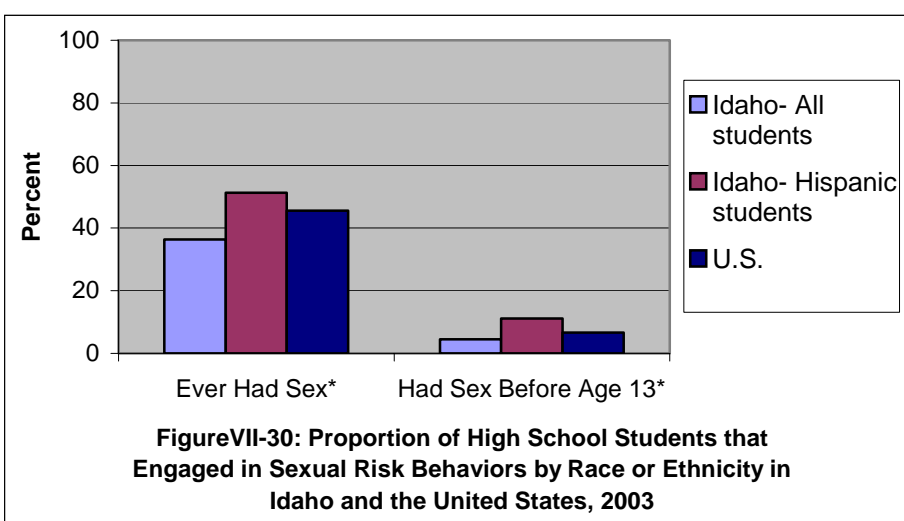
Source: Idaho Kids Count, 2003

## b. Sexual Risk Behaviors

### i) Sex Initiation and Protection

Across the Nation, the number of adolescents having sexual intercourse and becoming pregnant has been on the decline since the 1980s. In Idaho, 10 percent fewer adolescents reported ever having had intercourse than the national average (Figure\_). Also, slightly fewer Idaho adolescents have had intercourse before the age of 13 than those across the United States. There were no significant differences in either of these sexual risk behaviors between males and females (National Center for Chronic Disease Prevention and Health Promotion, 2004). These figures have likely contributed to the relatively low teen pregnancy rate in Idaho. During 2001-2003, the teen pregnancy rate in Idaho was 39.4 per 1,000 among 15- to 19-year-old females, compared to 43.0 per 1,000 in the United States. The pregnancy rate among youth under age 15 was also significantly lower in Idaho (Idaho Department of Health and Welfare, 2004g).

However, compared to White youth, Hispanic youth in Idaho were significantly more likely to report ever having sexual intercourse and were more likely to have had intercourse before age 13 (Figure VII-30). Similarly, the teen pregnancy rate among Hispanic 15- to 19-year-olds was 98.6 births per 1,000 females, versus just 38.9 births per 1,000 females among White teens during 2001-2003. Hispanic teen focus group participants felt teen pregnancy was very common among Hispanics, especially between ages 12 and 16. One participant indicated that he had nine Hispanic peers that were currently pregnant. They also perceived that most Hispanic teens did not use condoms, because of either impaired judgment due to alcohol and drug use or the limited availability and high expense of condoms in schools and the community. Sexual initiation seemed to occur at a very early age, just after puberty around 12 to 14 years of age.



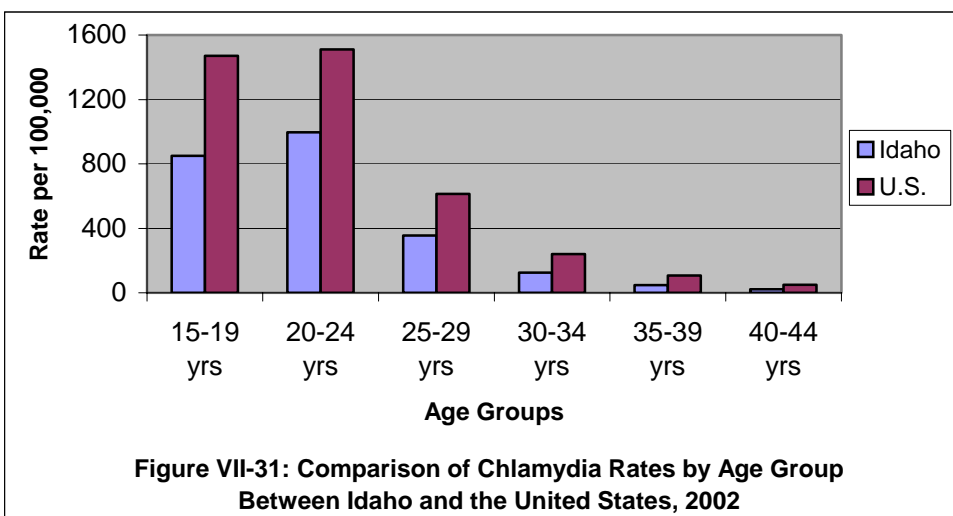
\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

It is also important to monitor the proportion of sexually active youth that use protection to prevent pregnancy and sexually transmitted infections (STIs). Healthy People 2010 specifically seeks to increase the proportion of sexually active, unmarried adolescents ages 15-17 that use

contraception and barrier protection. PRATS is the only statewide survey to assess whether individuals use protection during sex, but PRATS is administered only to females ages 18 and older. No comparable statewide surveys in Idaho currently exist that specifically target male and female adolescents. In fact, Idaho is one of the few States that have consistently excluded questions regarding contraception and barrier protection in its version of the YRBS each year since the initiation of the national survey in 1991. This is a critical omission on the Idaho YRBS, given that nationally one in four sexually active teens will acquire a new STI every day (National Conference of State Legislatures, 2004).

In the absence of data specifically indicating contraceptive and barrier protection use, some data on STI rates among adolescents are available and can shed light on risky sexual behaviors in Idaho. Overall, the rate of new HIV infections has steadily declined in Idaho since the early 1990s, from 4.3 per 100,000 in 1990 to 3.4 per 100,000 in 1999. The incidence rate of HIV among males declined the most, while the rate among females has remained relatively low (Idaho Department of Health and Welfare, 2001). The majority of HIV cases in Idaho have occurred in adults over the age of 19. Just 4 percent of HIV cases occurred in children under 20 years old in 1998 (IDHW Bureau of Health Policy and Vital Statistics, 1999). In 2001, Idaho had one of the lowest HIV infection rates in the country across all age groups (Division of STD Prevention, 2004).

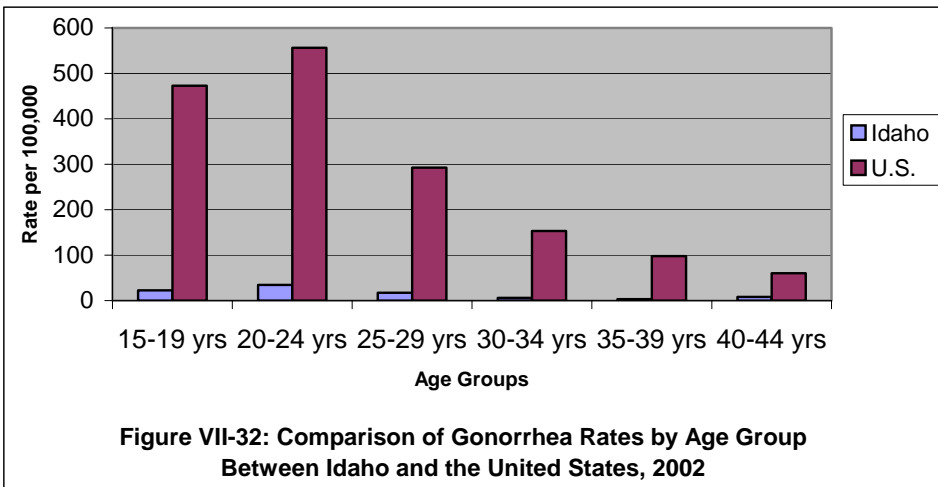
Despite the low HIV infection rate, the prevalence of all STIs has increased among adolescents aged 15-19 years, from 7.1 per 1,000 in 1999 to 8.7 per 1,000 in 2002 (Idaho Department of Health and Welfare, 2004g). The most common STI since the early 1990s has been chlamydia. By 2002, 94% of all reportable cases of STI were chlamydia (Idaho Department of Health and Welfare, 2004g). Females have been more at risk than men for contracting this STI, comprising about three quarters of cases (Idaho Department of Health and Welfare, 2001). In addition, Hispanics are also at a disproportionately high risk for chlamydia, they accounted for 13% of cases in 2004 (Idaho Department of Health and Welfare, 2004e). The largest differences in rates occur across age groups. Nearly 80% of the cases throughout the 1990s occurred among 15-24 year olds (Idaho Department of Health and Welfare, 2001). This trend continued in 2002, as the large majority of cases occurred among adolescents and young adults (Figure VII-31). However, rates of chlamydia in Idaho were lower across all age groups when compared to the national average. Untreated chlamydia can lead to pelvic inflammatory disease, a very serious condition that can cause ectopic pregnancies, infertility and chronic pain (Boonstra, 2004).



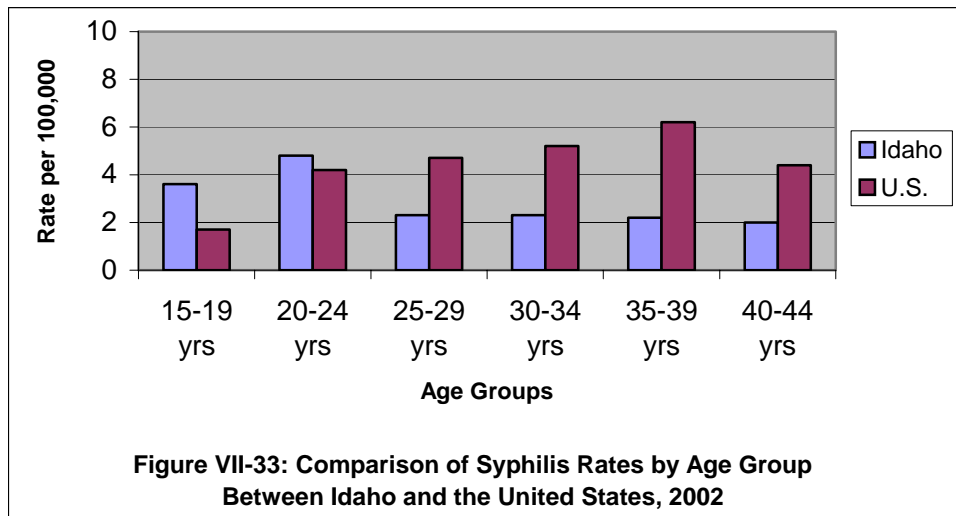
Sources: Idaho data is from IDHW STD/AIDS Program (2003), and U.S. data is from CDC Division of STD Prevention (2004).

The second most common STI in Idaho has been genital herpes, comprising 17% of all reportable STIs in 1999. Like chlamydia, genital herpes has been much more common in females, who comprised over 80% of cases in 1999. Unfortunately, genital herpes was no longer a reportable disease in Idaho after 1999. The total number of cases reported had been on the decline since 1992 (Idaho Department of Health and Welfare, 2000f). Genital herpes is currently incurable, but drug treatment has helped those infected with the virus manage the disease (Boonstra, 2004). Discomfort and inconvenience are usually the worst problems resulting from untreated genital herpes. However, those with compromised immune systems are likely to have more severe outbreaks. Also, untreated herpes often increases the risk of getting and spreading HIV.

Gonorrhea rates have fluctuated since the early 1990s, but have remained relatively low at 7.3 cases per 100,000 persons in 2002 (Idaho Department of Health and Welfare, 2004g). However, infection is over twice as high among adolescents ages 15-19 years at nearly 23 cases per 100,000 (Figure VII-32). As with chlamydia, Idaho's gonorrhea rates are much lower than the national rates across all age groups. The prevalence of syphilis has also been relatively stable over the past decade and represents the least common STI reported, averaging just 19 total cases per year from 1992 to 2002 (Substance Abuse Social Indicators, 2004). In 2002, the rate of syphilis was 1.7 cases per 100,000. However, when examining infection rates by age, youth ages 15-24 were nearly twice as likely as older age groups to contract syphilis (Figure VII-33). Rates of infection for this age group is even higher than the national average. This is particularly concerning given that the national trend indicates that older adults ages 30-39 are most at risk, not youth.



Sources: Idaho data is from IDHW STD/AIDS Program (2003), and U.S. data is from CDC Division of STD Prevention (2004).



Sources: Idaho data is from IDHW STD/AIDS Program (2003), and U.S. data is from CDC Division of STD Prevention (2004).

The prevalence of Hepatitis B has remained relatively stable in the past decade and has remained relatively low, with 8.6 cases per 100,000 persons in 1999. Adolescents and young adults are at a lower risk of infection as the majority of cases occur among 25-44 year olds (Idaho Department of Health and Welfare, 2001). Gonorrhea and syphilis can be cured by antibiotics, while Hepatitis B is incurable but can be managed with medication. However, a successful treatment outcome with each of these STIs depends on early detection (Boonstra, 2004).

Other STIs common among youth include human papillomavirus (HPV) and trichomoniasis. Unfortunately, neither of these STIs are currently reportable in Idaho and thus there is no available statewide data to describe their prevalence. HPV is the most common STI among youth in the country, accounting for over 50% or 4.6 million new cases of STIs in 2000 (Boonstra, 2004). Trichomoniasis accounted for over 20% of new STIs in the nation's youth in 2000. Both can be cured with antibiotics (Boonstra, 2004).

## ***ii) Reproductive Health Services***

There are a number of reproductive health services available for adolescents in Idaho. IDHW provides gynecological services, such as Pap smears and pelvic examinations, family planning counseling, and contraceptives such as condoms, injectibles and Emergency Contraception through the Idaho Reproductive Health Program at 41 different reproductive health clinics around the state (Idaho Reproductive Health Program, 2005). Planned Parenthood of Idaho also offers these services in their Boise and Twin Falls Offices. Adolescents enrolled in either Medicaid or CHIP have coverage for basic gynecological services and family planning services and supplies (National Conference of State Legislatures, 2004). Each of these clinics accept all public and most private insurance plans and provide sliding fee scales for those paying out-of-pocket.

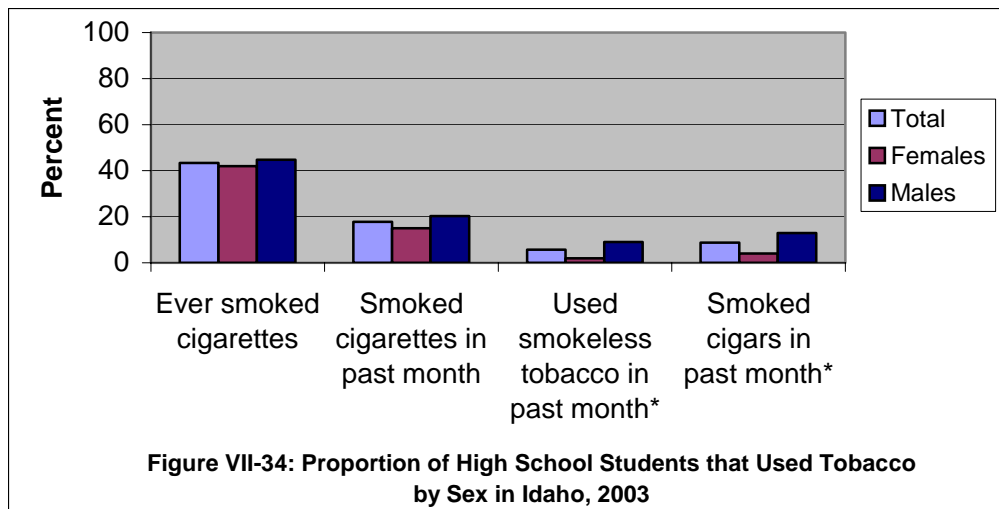
The Department of Education also supports several special programs around the state to allow pregnant girls and those with young children up to the age of 21 the opportunity to obtain a high school diploma. The Marian Pritchett High School is one such school established 1921 in Boise. Marian Pritchett accepts students from all school districts. Teen Parent Alternative serves the Nampa School District and offers instruction at Nampa High School. The Teen Parent Center in Pocatello serves students in Southeast Idaho. Each of these programs provide students with special instruction on infant care, assist in helping students access a range of social services such as Medicaid and WIC, and may help students get to medical appointments (Idaho CareLine, 2005).

The Idaho STD/AIDS Program receives Federal funding to provide testing, treatment and prevention services for Idaho's reportable STIs. These services are administered via contracts with district health departments and community-based organizations. Idaho's reportable STIs include chlamydia, HIV, AIDS, gonorrhea, syphilis, and Hepatitis B and C (Idaho Department of Health and Welfare, 2004d). Other common STIs, such as genital herpes, bacterial vaginosis, and HPV are not currently reportable diseases and thus are not funded by the IDHW's program. However, district health departments often use additional funds to cover a more comprehensive list of STIs. Planned Parenthood of Idaho also tests for a full range of STIs.

## ***iii) Substance Use***

### ***Substance use prevalence:***

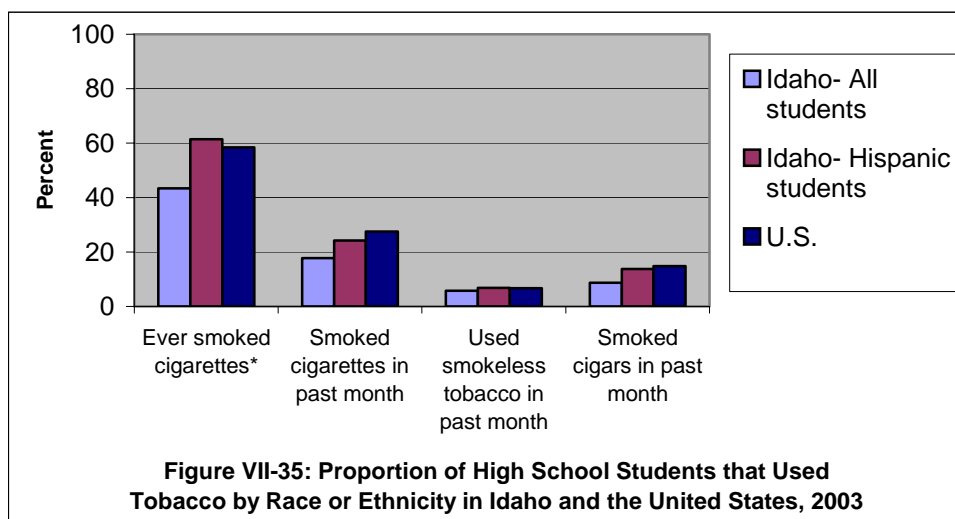
Nationally, smoking among adolescents increased during 1990, peaking near 1995, but has since declined (Burns and Johnson, 2001). Idaho's adolescents have followed this trend, as the proportion of students who have ever smoked and the proportion who have smoked in the past 30 days have both significantly declined between 2001 and 2003. Moreover, 20 percent fewer Idaho students have smoked in their lifetime and 15 percent fewer Idaho students have smoked in the past month compared to the national averages (National Center for Chronic Disease Prevention and Health Promotion, 2004). Idaho has already met Healthy People 2010 goals for both of these smoking indicators. There were, however, some sex differences in tobacco use behaviors. While females were as likely as males to have smoked ever or to smoke cigarettes currently, females were significantly less likely than males to use smokeless tobacco and cigars (Figure VII-34).



\*Indicates a significant difference between male and female students

Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

Despite the overall decline in smoking among youth, sizeable racial and ethnic disparities have developed in smoking prevalence among America's youth since the mid-1970s. White adolescents have been much more likely to smoke cigarettes than either Hispanic or Black adolescents (Burns and Johnson, 2001). In stark contrast, Idaho's adolescents have experienced the reverse trend. Hispanics in Idaho were significantly more likely than all students to have ever smoked cigarettes in their lifetime and were equally likely to be current tobacco users (Figure VII-35).

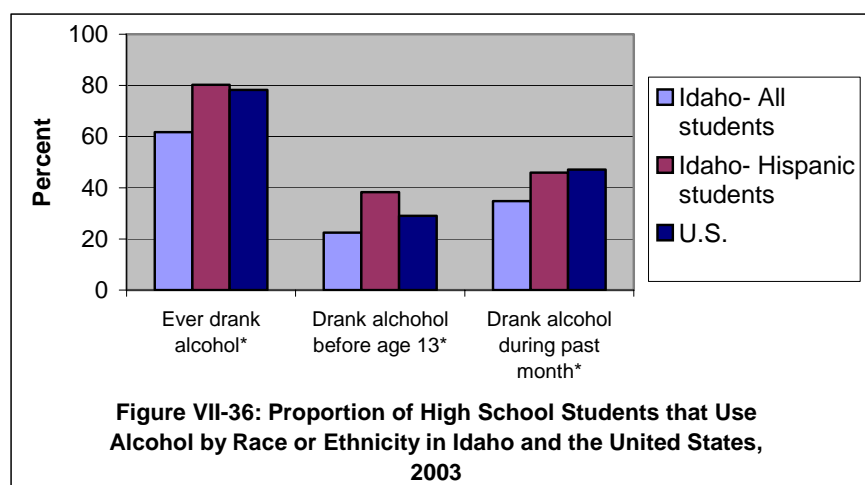


\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho

Source: National Center for Chronic Disease Prevention and Health Promotion, 2004



Adolescent alcohol use has declined steadily in the United States since the late 1990s (Idaho Department of Education, 2003a). Rates of adolescent alcohol use have been significantly lower in Idaho than in the Nation as a whole. During 2003, Idaho's high school students were less likely to have ever drunk alcohol or to be current drinkers (Figure VII-36). In contrast, binge drinking, or consuming five or more drinks of alcohol on one occasion, has changed little among all adolescent ages since 1996 (Idaho Department of Education, 2003a) and is similar to the national average (National Center for Chronic Disease Prevention and Health Promotion, 2004). In 2003, nearly a quarter of Idaho high school students engaged in binge drinking (National Center for Chronic Disease Prevention and Health Promotion, 2004). Frequent binge drinking in adolescents is associated with poor school performance, a higher risk of experiencing an injury, and damaging property (Lyll, 1995). Interestingly, there was a significant regional difference in the prevalence of binge drinking, with 46 percent of Region I high school seniors engaging in binge drinking compared to just 25 percent in Region V (Idaho Department of Education, 2003a). There were no significant sex differences for any of these alcohol use risk behaviors (National Center for Chronic Disease Prevention and Health Promotion, 2004).



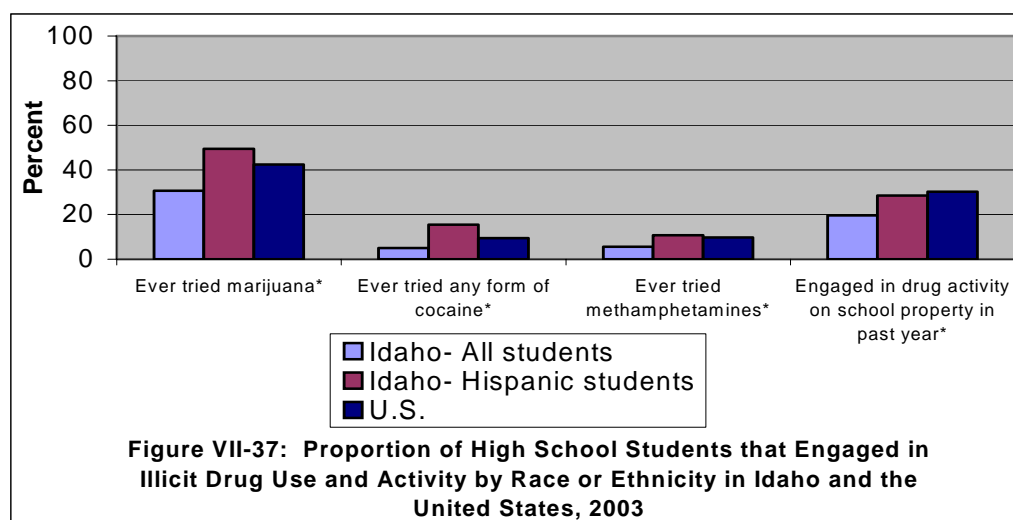
\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

Unlike the national trend, Hispanic students in Idaho were just as likely to engage in binge drinking as White students, 24 percent among all students (National Center for Chronic Disease Prevention and Health Promotion, 2004). Hispanic students were also significantly more likely to have drunk alcohol at some point during their lifetime, initiated drinking before age 13, and drank alcohol in the past 30 days (Figure VII-37). These figures mirror what Hispanic youth participants reported in our focus group. They perceived drinking alcohol to be particularly prevalent among Hispanic youth and indicated that drinking among their peers seemed to begin in the younger middle school grades.

Nationally, illicit drug use has declined since the mid-1990s (Centers for Disease Control and Prevention, 2004). In Idaho, drug use rates are at or below the national average across all types of drugs included in the YRBS. In particular, the proportion of Idaho students ever trying marijuana, one of the most frequently used drugs, was about 10 percent lower than the national average, and fewer Idaho students initiated marijuana use before age 13 and were current users in

2003 (National Center for Chronic Disease Prevention and Health Promotion, 2004). Students of all grade levels also perceived marijuana, cocaine, and methamphetamines as less easy to access than the national average did. For example, 58 percent of the nation's high school seniors reported methamphetamines as "fairly/very easy to get" compared to just 31 percent of Idaho's seniors (Idaho Department of Education, 2003a). In addition, Idaho students were less likely to engage in drug activity on school property than the national average, 20 percent compared to 29 percent (National Center for Chronic Disease Prevention and Health Promotion, 2004). There were no significant sex differences for any of these substance use risk behaviors (National Center for Chronic Disease Prevention and Health Promotion, 2004).

Similar to trends in alcohol use, there was also a significant regional variation in illicit drug use. Again, Region I had the highest proportion of adolescent drug users: 43 percent among high school seniors compared to only 21 percent in Region VI (Idaho Department of Education, 2003a). There were also significant disparities across racial and ethnic groups. Hispanic students were more likely to have used marijuana, cocaine, and methamphetamines ever or have engaged in drug activity on school property than White students in Idaho (Figure VII-37). Hispanic teens in our focus group perceived that over half of their peers use illicit drugs and often start using in middle schools. They indicated that marijuana, cocaine, "crystal meth," and LSD are among the most popular drugs.



\*Indicates a significant difference between Hispanic students and students of all races/ethnicities in Idaho  
Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

### ***Treatment and Prevention Programs:***

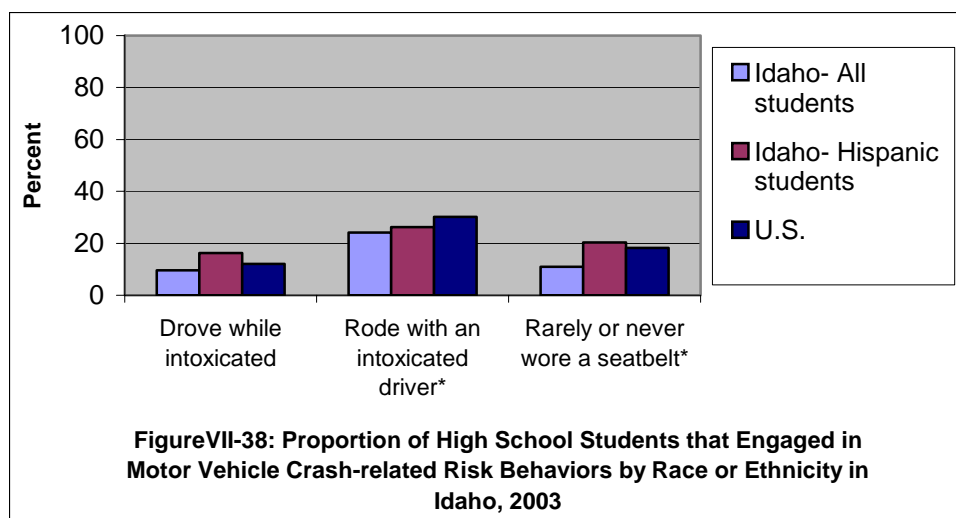
Among the students reporting substance use, relatively few adolescents appear to seek treatment for alcohol abuse. Marijuana was the most frequent primary drug of abuse, accounting for 41 percent of visits during 2001-2002. Nearly a third of clients sought treatment for alcohol abuse, representing the second most common primary drug of abuse. Less than 2 percent of the adolescents ages 15-19 years old reporting current alcohol use and/or engaging in binge drinking utilized public substance abuse treatment services for alcohol during 2001-2002. Methamphetamines were the third most frequent, accounting for 28 percent of visits. Excluding

alcohol, all other substances comprised only about 1 percent of public substance abuse treatment client visits. An important trend to note is that the number of methamphetamine visits has significantly increased in recent years. During 1999-2000, methamphetamine visits accounted for just 9 percent of total visits, but by 2001-2002, methamphetamine accounted for nearly 30 percent of visits, which were as common as alcohol visits. Intravenous drug users made up only 3 percent of visits (Substance Abuse Social Indicators, 2004). Overall, 75 percent of adolescent clients were enrolled in nonintensive outpatient programs. Over 80 percent of adolescent clients were between the ages of 15 and 17 (Substance Abuse Social Indicators, 2004).

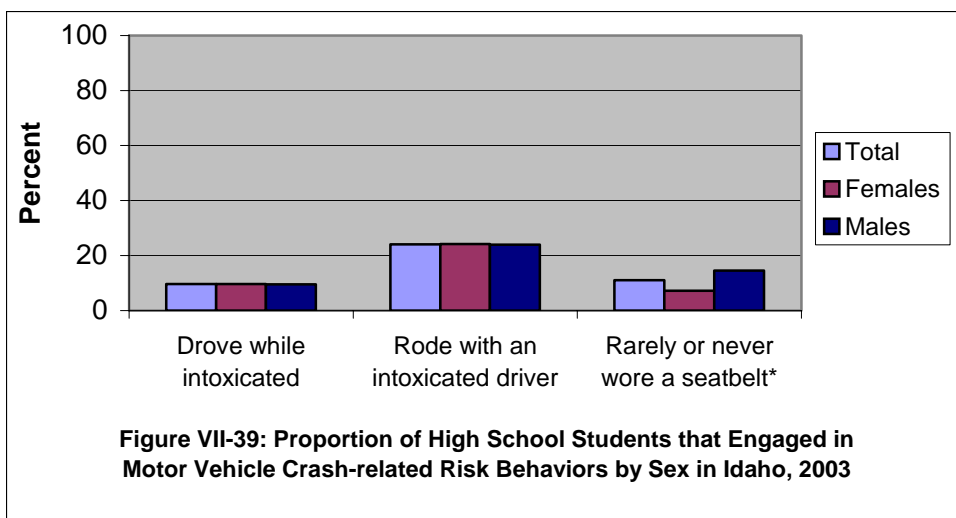
#### iv) Injuries

##### *Prevalence of injuries and risk behaviors:*

Two of the biggest risk factors for MVC-related mortality are drinking and driving and not wearing seatbelts. Idaho's juvenile arrests for driving under the influence of alcohol (DUI) has recently exceeded the national average, with 1.7 arrests per 10,000 youths age 10-17 compared to just 0.6 arrests for the Nation during 2000 (Idaho Kids Count, 2003). Healthy People 2010 seeks to reduce the proportion of adolescents riding with an intoxicated driver to 30 percent. White students in Idaho have already met this goal, but 36 percent of Hispanic students currently ride in a vehicle driven by someone who had been drinking alcohol (Figure VII-38). There were no significant sex differences for this MVC-related risk behavior (National Center for Chronic Disease Prevention and Health Promotion, 2004). Healthy People 2010 also seeks to increase the proportion of youth that use seatbelts to 92 percent. White students are much closer to reaching this goal than are Hispanic students: 90 percent of White students use seatbelts compared to just 80 percent of Hispanic students (Figure VII-38). Male students were significantly more likely to wear seatbelts never or rarely than were female students (Figure VII-39).



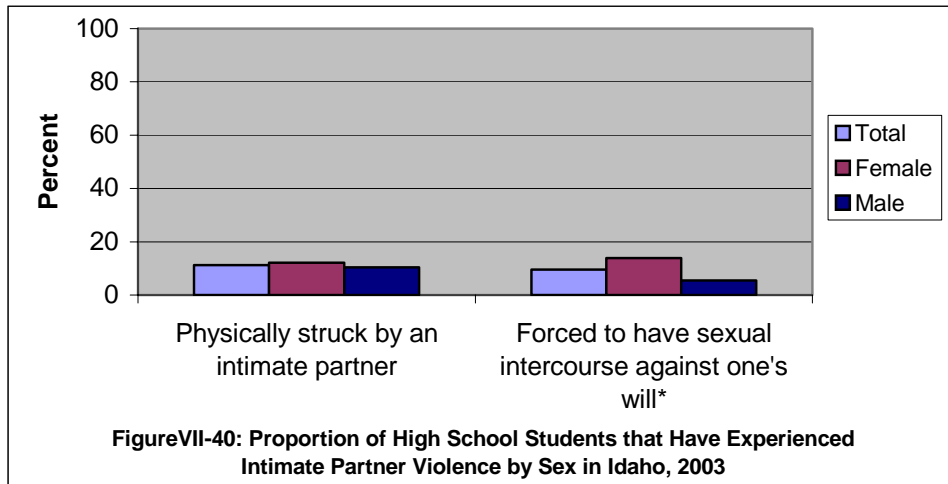
\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
Source: National Center for Chronic Disease Prevention and Health Promotion, 2004



\*Indicates a significant difference between female and male students

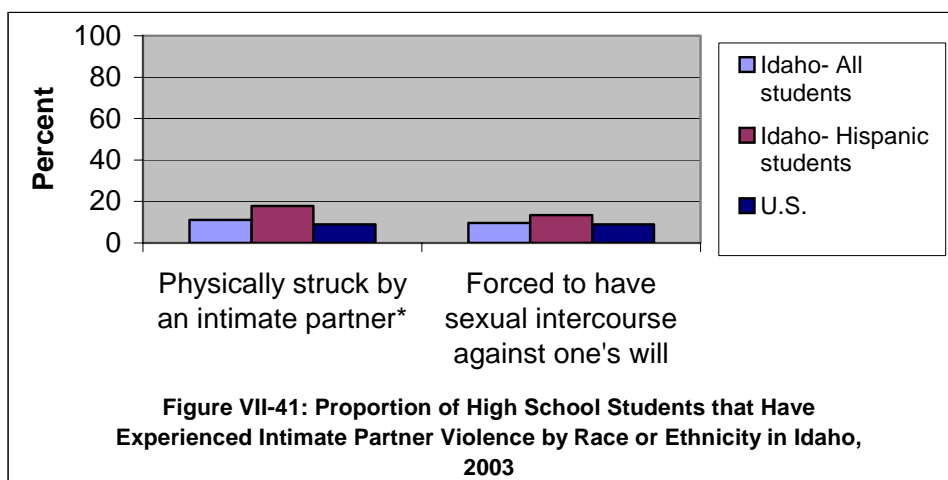
Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

Intimate partner violence (IPV) is a major problem among youth in America. All types of relationships, including those between same-sex partners, and both sexes can experience IPV. However, females in heterosexual relationships are thought to be the most common victims. It is estimated that between 20 and 30 percent of teen girls over age 13 have been physically, emotionally, or sexually abused by an intimate partner (Joyce, 2003). Pregnant adolescents are at particularly high risk for experiencing IPV, even higher than that of pregnant adults, and violence often continues into the postpartum period (Scheiman and Zeoli, 2003). However, a smaller proportion of adolescents indicate they have experienced IPV when surveyed. There were comparable numbers of students in Idaho and across the United States reporting they had been struck physically by an intimate partner, about 11 percent (National Center for Chronic Disease Prevention and Health Promotion, 2004). Interestingly, male students were just as likely to experience physical abuse by an intimate partner as were females students (Figure VII-40), which is similar to the national trend (National Center for Chronic Disease Prevention and Health Promotion, 2004). However, Idaho's female students were significantly more likely than male students to have been forced to have sexual intercourse against their will (Figure VII-40), similar to the national trend (National Center for Chronic Disease Prevention and Health Promotion, 2004). Hispanic students were equally likely to have been forced to have sexual intercourse against their will as students of all races and ethnicities but were significantly more likely to report being struck by an intimate partner (Figure VII-41).



\*Indicates a significant difference between female and male students

Source: National Center for Chronic Disease Prevention and Health Promotion, 2004



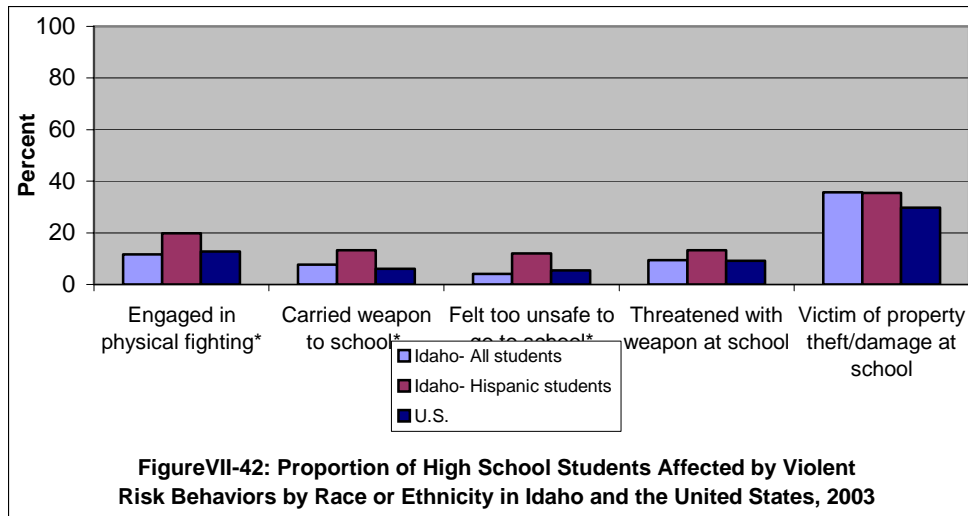
\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho

Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

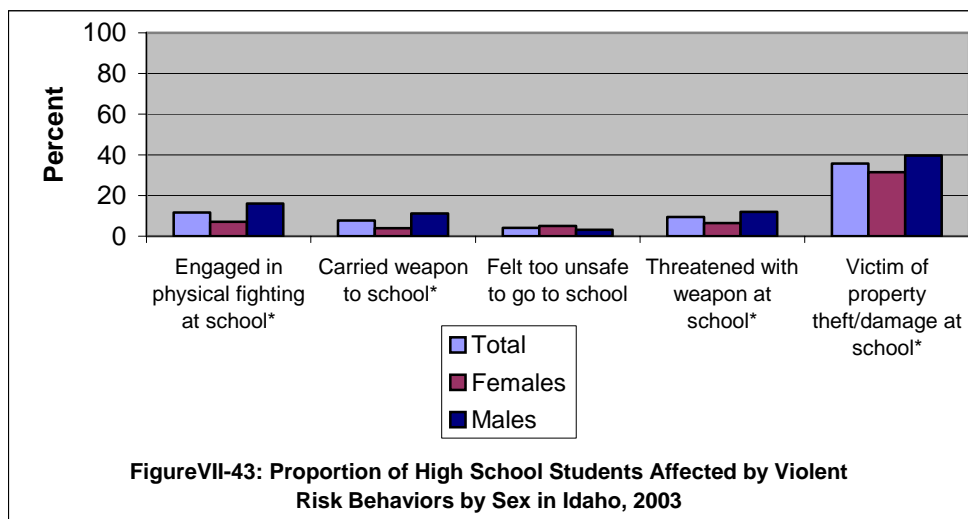
An even smaller proportion of adolescents reported incidents of IPV to official authorities. The majority of IPV victims reported in Idaho's police reports during 2003 were adult females ages 25-34, with juvenile female victims representing just 6 percent. Among the 20 percent of victims that were male, the majority were also adults between the ages of 25 and 44 years (Statistical Analysis Center, 2003). In addition, less than 1 percent of violent juvenile arrests were for forcible rape in 1997 (Idaho Department of Health and Welfare, 1999). It is important to note that these figures may represent a significant amount of underreporting, given that nationally only half of intimate partner violence incidents are reported to the police and even fewer such incidents, 40 percent, are estimated to be reported in Idaho (Statistical Analysis Center, 2003). Moreover, adolescent victims are even less likely than adult victims to report IPV incidents (Joyce, 2003).

Violence against nonintimate partners is also common among adolescents; nearly 900,000 youth ages 10-24 suffered injuries from violent acts nationwide in 2002. Homicide has become the second leading cause of death for Americans in this age group. The national homicide rate for adolescents ages 15-19 was 10.4 deaths per 100,000 in 1999 (Centers for Disease Control and Prevention et al., 2004). Idaho's adolescent homicide rate for this age group was much lower at 4.6 deaths per 100,000 in 2002 (Idaho Department of Health and Welfare, 2004g). The child firearm mortality rate in Idaho was higher than the national rate since the early 1990s, but began to decline in 1998. Idaho matched the national firearm mortality rate among children age 18 and under in 2000 at 2.2 deaths per 100,000 in 2000 (Idaho Child Mortality Review Team, 2003). Despite this lower risk of mortality from violence, Idaho's adolescents indicated they were just as likely to engage in a range of violent risk behaviors, such as physical fighting and carrying a weapon to school (Figure VII-42).

There were also important disparities among students that commit and are victims of violent behavior as well as their perception of violence. Hispanic students were significantly more likely to engage in violent risk behaviors than were White students, including carrying a weapon to school, skipping school because of feeling unsafe, and engaging in physical fighting on school grounds (Figure VII-42). The 2002 Idaho School Climate Survey asked all students about gang activity. Younger students were more than twice as likely to perceive gangs as causing trouble in their schools, with 26 percent of 6<sup>th</sup>-graders. Actual gang membership was highest in grades 8 and 10 and lowest in grades 6 and 12. Just 4 percent of 6<sup>th</sup>-graders reported gang membership, compared with 8 percent of 10<sup>th</sup>-graders. The Survey report did not stratify these responses by ethnicity, so it is unknown whether Hispanics are in fact more likely than other groups to join a gang. However, the Survey did indicate that between 28 and 41 percent of students, depending on grade level, felt that students of different races and ethnicities did not get along. Interestingly, younger students were more likely to report such racial and ethnic tension than did older students (Idaho Department of Education, 2003a). This may suggest that students learn to deal with each other's differences as they spend more time interacting with each other. Lastly, male students were significantly more likely than female students to have engaged in a number of violent risk behaviors, including physical fighting at school, carrying a weapon to school, being threatened with a weapon at school, and being the victim of property theft or damage (Figure VII-43).



\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
Source: National Center for Chronic Disease Prevention and Health Promotion, 2004



\*Indicates a significant difference between female and male students  
Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

Adolescents in Idaho that commit crimes may also be more likely to enter the criminal justice system. The juvenile arrest rate among 10- to 17-year-olds in Idaho has consistently exceeded the national average since the early 1990s. In 2000, Idaho's juvenile arrest rate was 11.1 per 1,000, while the national average was only 7.3 per 1,000 (Idaho Kids Count, 2003). Evaluation of the juvenile arrest statistics indicated that violent crimes only comprised a small minority, 9 percent in 1997 (Idaho Department of Health and Welfare, 1999). Among violent arrests, the majority were simple assaults (72 percent). Weapons arrests comprised just 12 percent of the violent arrests, and the numbers have declined 25 percent between 1995 and 1997.

### ***What Did Adolescents Say?***

*During the focus groups, Hispanic teens felt there was a high level of gang involvement among Hispanic youth, including males and females. Most indicated that coming from a recent immigrant experience, Hispanic youth often joined gangs to combat feelings of alienation and to find a place where they felt they belonged. Moreover, participants believed their peers joined gangs as early as 8 years old. Much of the gang experience is shaped by violence, such as drive-by shootings, and is driven by rivalry and sometimes racial tension with other gangs. Participants also felt that drugs and alcohol often exacerbated this kind of violent behavior.*

#### **v) *Prevention Services and Help***

The IDHW has focused on two main injury prevention areas, unintentional injuries and sexual violence prevention. Idaho's Unintentional Injury Prevention Program currently focuses on reducing injuries caused by falls among older adults over age 65 (Idaho Department of Health and Welfare, 2005b). There is no similar focus on reducing the most common causes of unintentional injuries among children and adolescents. IDHW also operates the Sexual Violence Prevention Program to reduce the statewide incidence of sexual violence by seeking to change knowledge, attitudes, and behaviors. One of the activities includes a statewide health promotion campaign that includes rape prevention commercials, which are aired on radio stations. Some of these aids are male-focused to complement the "Engaging Men" component to help prevent abuse before it starts or to encourage male abusers to seek treatment. IDHW has also funded a number of programs created by Idaho's universities, such as activities for Sexual Assault Awareness Month. Lastly, IDHW supports a number of youth-specific, peer-led activities in schools to promote safe relationships (Idaho Department of Health and Welfare, 2005c).

The Idaho Council on Domestic Violence and Crime Victim Assistance oversees shelters, safe houses, hotlines and other support services to assist IPV victims. IPV victim data stratified by age could not be located for this report, so it is unknown how many adolescents use these services. However, this number has likely increased in recent years. The number of crisis calls received by the Council has more than tripled between 1986-1987 and 2000-2001. The number of clients served at shelters has also increased, 2210 individuals were served in 2000-2001 (Idaho Council on Domestic Violence & Crime Victim Assistance, 2003).

There are a number of community-based programs to prevent violence in youth. The Idaho Youth Ranch is one of the largest organizations offering separate programs, including group homes, family services, adoption services to all children and families in Idaho. The Idaho State University Institute of Rural Health also operates Red Flags Idaho, which helps parents identify emotional and behavioral problems in their children before serious problems arise (Idaho CareLine, 2005).

#### **5. *Adolescent children obtain the health and lifestyle information and education that support lifelong positive health behaviors.***

In addition to health services, adolescents also benefit from timely and comprehensive health education to help them avoid health risks and make more positive decisions. One of the most important providers of health education is schools. Health promotion campaigns also offer



valuable information to youth. Together, these education services can help Idaho's youth lead more health-promoting lives.

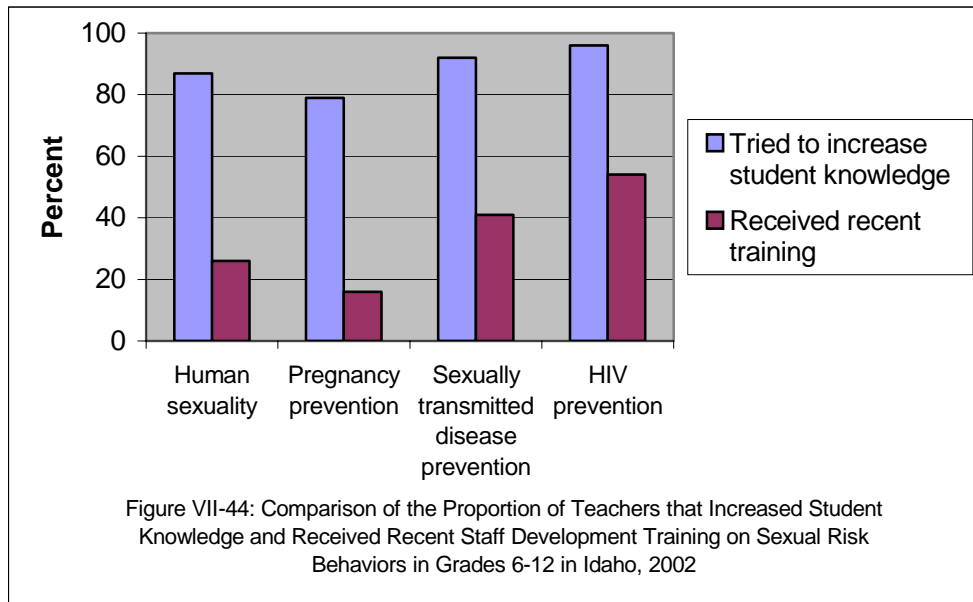
Idaho's schools have a health education coordinator at the State level. About half of schools, 49 percent, required students to have at least one health education course in 2002 (Idaho Department of Education, 2003b). Schools are required to teach the following standards to students in grades 7-12:

- Acquire the essential skills to lead a healthy life.
- Demonstrate the ability to practice health-enhancing behaviors and reduce health risks.
- Demonstrate the ability to use communication to enhance health.
- Organize, analyze, and apply health information practices and services appropriate for individual needs.
- Understand and demonstrate the key components to positive mental and emotional health (Idaho State Board of Education, 2003).

SHEPS is administered to school principals and lead health education teachers in middle and high schools to monitor the current status of school health education. Results from Idaho's 2002 SHEPS are presented in the following sections.

#### **a. Sex Education**

Among schools with a required health education course, over 75 percent of teachers taught students about human sexuality and pregnancy, STI, and HIV prevention in 2002 . However, a much smaller proportion of teachers reported receiving staff development training during the past 2 years concerning each of these topics. Specifically, 41 percent received recent training regarding human sexuality, 26 percent regarding STI prevention, and 16 percent regarding pregnancy prevention. Over half of these lead education teachers expressed that they would like to receive more training on each of these topics (Idaho Department of Education, 2003b). The majority of lead health education teachers have received recent HIV prevention training, 54 percent (Figure VII-44).



Note: Recent staff development must have been offered in the past 2 years.  
Source: Idaho Department of Education, 2003b

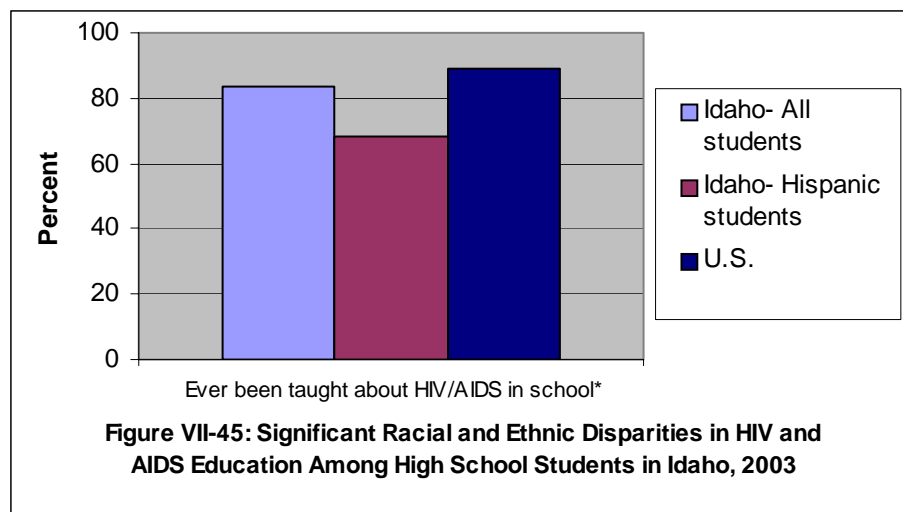
Interviews with school health officials indicated that students in middle and high schools are taught about abstinence as a viable method to prevent pregnancies but are not taught about contraceptives such as birth control pills, patches, and injections. In line with school policy, the Idaho Governor's Council on Adolescent Pregnancy Prevention (IGCAPP) has also chosen to focus solely on reducing teen pregnancy in Idaho by "increasing the number of teens choosing abstinence" (Association of Maternal and Child Health Care Programs, 2004). Since 1994, IGCAPP has established 27 community coalitions across the State and launched a media campaign that has reached over 90 percent of residents between the ages of 10 and 54. The proportion of teens reporting that these ads influence their behavior has increased from 28 percent in 1996 to 61 percent in 2000. Similarly, the proportion of parents reporting that these ads prompted discussion with their teens about sex increased in the same period of time to from 38 percent to 50 percent (Association of Maternal and Child Health Care Programs, 2004).

Abstinence-only education in schools and the statewide IGCAPP abstinence campaign has likely contributed to helping Idaho move closer to reaching the main Healthy People 2010 goal for sexual intercourse: to increasing the proportion of adolescents aged 15-17 years who have never engaged in sexual intercourse to 75 percent (Centers for Disease Control and Prevention, 2004). During 2003, about 64 percent of Idaho's high school students reported never having had sexual intercourse (National Center for Chronic Disease Prevention and Health Promotion, 2004). It is important to note that Healthy People 2010 has created additional goals to increase formal instruction about birth control methods and barrier methods of preventing STIs in schools before students reach the age of 18 (Centers for Disease Control and Prevention, 2004).

The IGCAPP campaign does not address either of these topics. Health officials also indicated that only high school students are taught that condoms can be used to prevent infection. Middle school students are taught about the existence of STIs and how these infections are spread but

not about methods of protection. Therefore, younger adolescents may lack critical knowledge to protect themselves from STIs if they choose to become sexually active.

The majority of high school students in Idaho have received some HIV and AIDS education in schools, but this figure is still slightly lower than the national average (Figure VII-45). Hispanic students were particularly at risk for being undereducated about sexual risk behaviors, with 16 percent fewer Hispanic students reporting they had received HIV and AIDS education. When lead health education teachers were asked about what types of HIV prevention topics were covered, 95 percent indicated they taught that abstinence is the most effective way to avoid HIV infection, but only 60 percent discussed the efficacy of condoms in preventing HIV. Moreover, just 20 percent of teachers described to their students how to use a condom correctly (Idaho Department of Education, 2003b).



\*Indicates a significant difference between Hispanic students and students of all races and ethnicities in Idaho  
Source: National Center for Chronic Disease Prevention and Health Promotion, 2004

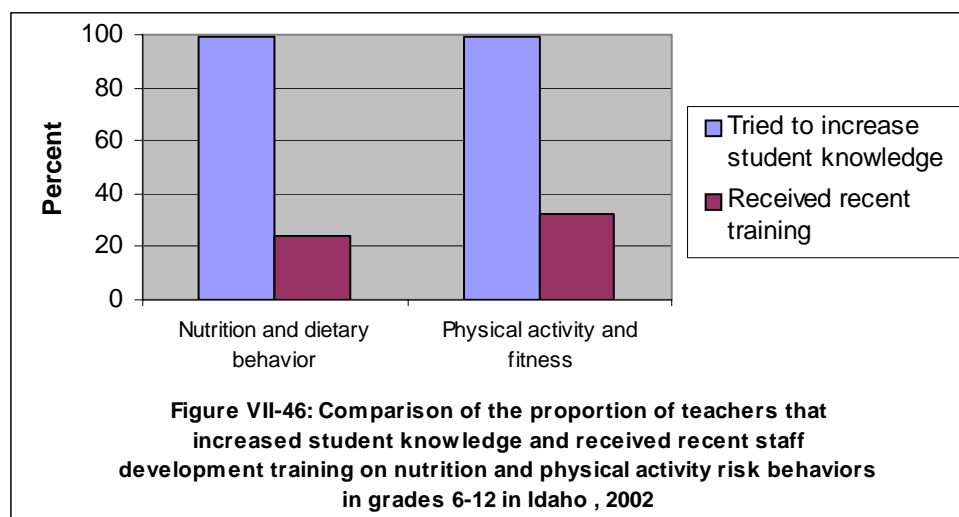
As previously mentioned, there is a lack of data regarding the use of birth control and barrier protection against STI infection among Idaho's youth. In addition, there are also virtually no data regarding the frequency of noncoital sexual behavior and the use of STI protection when engaging in such behaviors. Noncoital sexual behaviors may include mutual masturbation, oral sex, or anal intercourse. Without this data, it is unknown how many of Idaho's youth engage in these practices and may be at risk for STI infection.

## **b. Nutrition and Physical Education**

Schools have become a much more important part of children's daily diets, as over 50% of school-age children across the country participate in the USDA's school meal programs. During the 2003-2004 school year, 31% of all K-12 students in Idaho received free lunch and another 11% received reduced lunch (Idaho Department of Education, 2004). However, school children

now also have greater access to alternative food selections, which are collectively called “competitive foods” by the USDA, than ever before. Competitive foods have been shown to be high in fat, sugar, and calories, but low in essential nutrients (Food & Nutrition Service, 2001). Access to vending machines ranges from 27% in elementary schools to 96% in high schools and access to fast food providers ranges from 16% to 26%, respectively (Anderson et al., 2003). As a result, these Federal school meal programs are no longer the primary provider of food to America’s students. During 2002, 89% of Idaho’s middle and high schools had vending machines where students can purchase snack foods and beverages (Idaho Department of Education, 2003b).

Action for Healthy Kids State (AFHK) is a nationwide initiative that seeks to improve nutrition and physical education in schools. In 2004, Idaho’s AFHK State Team developed “Idaho Recommendations for Promoting a Healthy School Nutrition Environment” to help ensure that all food served in Idaho’s schools meet USDA’s dietary guidelines. These recommendations, endorsed by the State Superintendent of Public Instruction, includes guidelines for both vending machines and a la carte sales as well as a list of 150 recommended nutritious snack foods (Idaho Department of Education, 2004b). School compliance with these recommendations is currently voluntary. In addition, health education teachers cover dietary and fitness topics in required health education course. The large majority of health education teachers have tried to increase student knowledge on both nutrition and physical activity in 2002. However, a much smaller proportion, less than 40%, of teachers have received recent staff development training (Figure VII-46).



Note: Recent staff development must have been offered in the past 2 years.

Source: Idaho Department of Education, 2004b

Many schools in Idaho receive Nutrition Education and Training Grants, which serve students, parents, teachers, and food service personnel. Participants receiving training learn about the nutritional value of foods and the relation between food and health. Food service personnel are also encouraged to use an innovative approach to increase nutrition awareness in the cafeteria. In 2002-2003, the Idaho Department of Education trained 1,509 participants (Idaho Department of Education, 2004). Despite these efforts, Idaho’s schools continue to lack a food service coordinator at the State level, compared to 97 percent of States across the Nation that currently

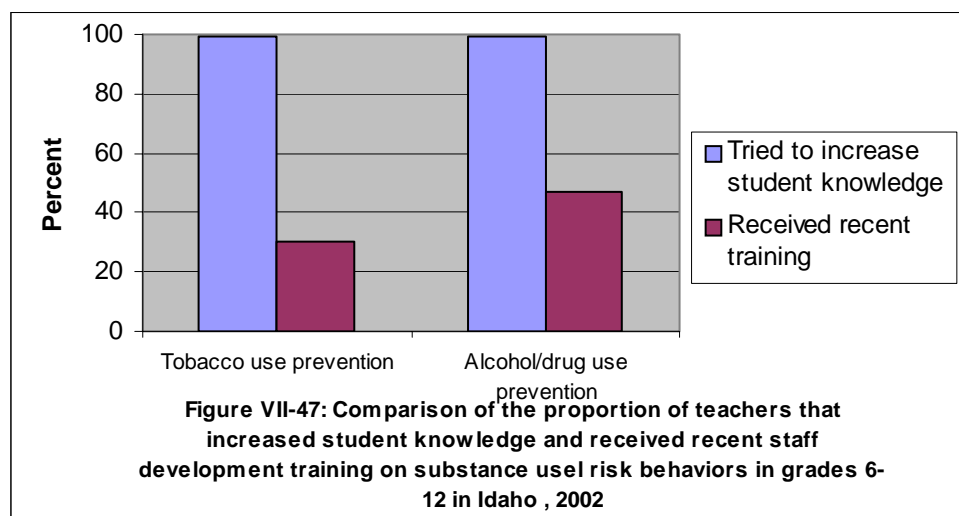
have such coordinators (Hayes et al., 2004). State funding for nutrition education has also recently been in jeopardy in Idaho, as more emphasis has been placed on strengthening basic education, like math and science (Action for Healthy Kids, 2002).

Idaho also does not have a state physical education coordinator, compared to 69% of states across the nation (National Center for Chronic Disease Prevention and Health Promotion, 2001). In addition, there are no state standards for physical education content. Students in grades 1-8 are required to participate in physical education, but there are no minimum time requirements. Also, students in grades 9-12 are offered physical education, but are not required to participate (American Council for Fitness and Nutrition, 2005). There has also been a de-emphasis on physical education in schools by the Idaho Department of Education because of a desire to redirect resources to basic education. There is currently no state funding for physical education, while funding at the school level has recently been decreased (Action for Healthy Kids, 2002).

## c. Substance Use Education

### i) Tobacco

The vast majority, 98 percent, of Idaho's middle and high schools have adopted a policy to prohibit cigarette smoking by students on school grounds. Among schools that require a health education course, 99 percent tried to increase student knowledge on tobacco use prevention (Figure VII-47). However, just 30 percent of health education teachers received tobacco use prevention training in the past 2 years, although 61 percent indicated that they would have liked to receive such training (Idaho Department of Education, 2004b).



Note: Recent staff development must have been offered in the past 2 years.

Source: Idaho Department of Education, 2004b

The majority of youth in Idaho appear to recognize the enormous health risks of smoking. During 2003, Idaho's youth were equally knowledgeable about the health risks of smoking across all grade levels to the national average. By grade 12, nearly three-quarters of Idaho's students perceived smoking a pack of cigarettes daily as a "great risk" (Idaho Department of

Education, 2003a). Another important measure of tobacco use knowledge is the proportion of students that currently use tobacco that attempt to quit. Healthy People 2010 has established a goal to increase tobacco use cessation attempts by adolescent smokers in grades 9-12 to 84 percent. Unfortunately, Idaho has yet to meet this goal, as only 53 percent of Idaho's youth smokers had tried to quit in the last year during 2003 (National Center for Chronic Disease Prevention and Health Promotion, 2004).

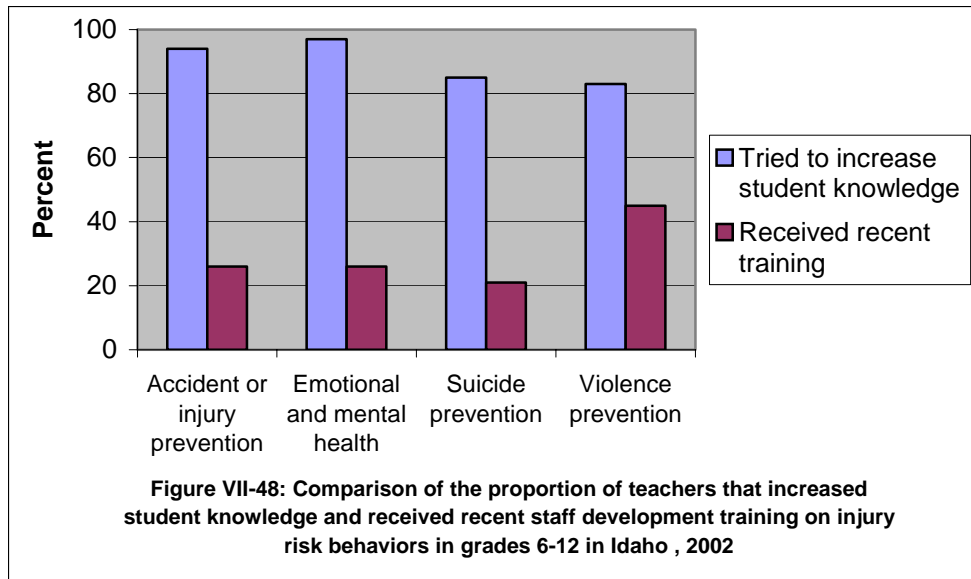
## ***ii) Alcohol and Illicit Drug Use***

All of Idaho middle and high schools in Idaho prohibit alcohol and illicit drug use on school grounds (National Center for Chronic Disease Prevention and Health Promotion, 2001). Among schools that require a health education course, 99% of teachers tried to increase students' knowledge on alcohol or other drug use prevention. Nearly half, 47%, of health education teachers received alcohol and drug use prevention training in the past two years (Idaho Department of Education, 2003b).

One of the riskiest substance use behaviors is binge drinking, particularly because youth may not be aware of its health risks. In a national study, 91 percent of women and 78 percent of the men who were frequent binge drinkers considered themselves to be moderate or light drinkers (Lyall, 1995). The lack information about the seriousness of binge drinking may be even greater among Idaho's youth. Fewer middle and high school students in Idaho perceived themselves at "greater risk" of harm by binge drinking than did most American students. This was especially true among younger students, only 38% of Idaho 8<sup>th</sup> graders found binge drinking to be a risky health behavior, compared to 57% nationwide. This disparity in health knowledge is particularly alarming given the increasing numbers of younger students who report drinking at an earlier age than do older students (Idaho Department of Education, 2003a).

## ***d. Injury Prevention Education***

All of Idaho's middle and high schools have a range of policies to prevent violence from taking place among students on school grounds, including prohibiting school fighting, weapons possession, gang activities, and harassment of other students (Idaho Department of Education, 2003b). In addition, 53 percent of schools have uniformed police, undercover security, or security guards to prevent and respond to student violence (Idaho Department of Education, 2003b). Among schools requiring health education courses, teachers have tried to increase student knowledge on both unintentional and intentional risk behaviors (Figure Vii-48). However, there was a particularly large disparity in the proportion of health education teachers reporting they had received training on these health topics in the past two years. For example, only a quarter of teachers indicated they received recent accident or injury prevention training, although 48 percent indicated they would have liked to receive it (Idaho Department of Education, 2003b). Similarly, 45 percent of teachers received recent violence prevention training, but 80 percent of teachers would have liked to receive it.



Note: Recent staff development must have been offered in the past 2 years.

Source: Idaho Department of Education, 2003b

## Summary

Although children and adolescents in Idaho were equally likely to be insured as the rest of the national population, they had less access to a number of basic and specialized health services. Idaho's children are less likely to have a regular primary care provider, receive EPSDT screenings if enrolled in Medicaid, or be up to date on all vaccinations recommended by the CDC. There is also a need for State officials to respond to rising national health issues such as the childhood obesity epidemic, the continuing high rates of unintentional injuries among children, and the rising rates of STIs among adolescents. Moreover, Idaho has relatively low levels of committed funding to a range of child and adolescent services, particularly subsidized child care and mental health services, compared to the Nation as a whole, which has only increased already high unmet needs.

Fortunately, Idaho has undertaken a number of recent initiatives to address some of these issues and has increasingly used the Healthy People 2010 objectives to guide policy and health promotion issues. Among the strongest of these initiatives has been the creation of statewide taskforces that promote a high level of collaboration and communication between State agencies, healthcare providers, community groups, and other stakeholders to address complex problems. Taskforces have recently been started to target asthma, mental health, oral health, and child care. Still, there is much more that can be done to strengthen the MCH system to address better the needs of children and adolescents in Idaho.

## Idaho Child Outcomes

### **Children receive ongoing and preventive health care consistent with the Bright Futures Health Supervision Guidelines.**

#### **Summary**

- Children in Idaho are more likely to lack a medical home than the national average.
- A significant proportion of children are eligible for public programs but are not currently enrolled.
- Idaho has created a number of statewide initiatives that promoted a great deal of interagency collaboration to address many children's issues in Idaho.
- A number of emerging children's health issues have yet to receive sufficient government attention, including childhood obesity, diabetes, and hypertension.
- There is a lack of data available to measure the extent of some health risks and childhood conditions.

#### **Analysis**

- The recent CHIP expansions can increase enrollment in public insurance, but only with adequate outreach and advertisement. Health insurance is one of the primary means of access to medical homes.
- More support and coordination of services is needed to increase children's access to primary care. Much of this can be achieved by enhancing the existing health infrastructure, such as increasing outreach to enroll more eligible children in Medicaid and CHIP or increasing the number of children that receive their regular EPSDT screenings.
- Programs like Head Start and EPSDT help identify health problems early on, often when treatment is likely to be the most effective.
- State agencies must address emerging health issues with primary prevention strategies before they become major problems in the child population.
- Some of the difficulty in responding to children's health issues stems from the lack of adequate data to describe their unique health risks. Existing data is often not stratified by age or excludes certain children altogether.

### **Children are cared for in environments that protect health, promote their well-being, and ensure their safety.**

#### **Summary**

- There is not enough investment at the State level to support early childhood development and education.
- Existing early childhood programs do not provide children and families with same benefit levels compared to the rest of the nation.
- Older children also need more educational opportunities once they finish high school.
- Support for school-based health services has significantly declined in recent time.
- There was substantial regional variation in the adequacy of child maltreatment services.
- Idaho has sustained higher-than-average child mortality rates due to unintentional injuries and suicide over the past decade



## Idaho Child Outcomes

### Analysis

- Early childhood programs are not reaching all children in need of these services. The strict eligibility requirements restrict a number of near-poor families that cannot afford to pay for child care and preschool on their own. The lack of a State-funded preschool program could significantly improve access to critical early learning skills for Idaho's young children.
- Child care homes and facilities also are in need of increased standards to increase the quality of care received, while child care staff could benefit from more widely available training opportunities.
- There is a need for more higher education opportunities for older adolescents to help break the cycle of poverty that many individuals find themselves in and to help provide a better future for their families.
- The State's child maltreatment services need to be unified into a strong system that provides adequate and timely responses to maltreatment reports in all areas of the State. Moreover, child protection agencies must work to ensure that victims ultimately end up in stable homes, even if this home is not with their parents.
- Although there has recently been a statewide taskforce to address adolescent suicide, no similar taskforce has been established to address unintentional injuries among children. Much of the increased risk of injury among children is due to MVC. MVC injuries may be prevented by stricter seatbelt enforcement, drinking and driving awareness campaigns, and similar actions.

### **Families have access to and use services that strengthen parenting skills appropriately.**

#### Summary

- Although there are a number of parenting programs available in Idaho, there is a great deal of regional variation in the number and type of programs offered.
- Even when parenting programs are available, many parents indicated that they were unaware of them or how to search for such programs.
- Some programs also charged a fee, which may be a deterrent for many low-income families in need of these services.

#### Analysis

- Parenting programs appear to be organized at the local and community levels but really are organized at the State level. Collaborating at the State level could help ensure that a range of parenting services are offered in all regions and that they are offered at a sliding-scale fee for low-income participants.
- Parenting services need much more advertisement to alert families about their availability and to alert them how helpful they can be.

## **Adolescent children use ongoing health services appropriate to their stage of growth and development.**

### **Summary**

- Overall, adolescents in Idaho were less likely to engage in a number of risk behaviors than the national average.
- Idaho's Hispanic adolescents, however, were much more likely than White adolescents to engage in most risk behaviors included in surveys.
- Non-HIV STI rates have increased in recent years among Idaho's adolescents.
- There was lack of data regarding the proportion of youth that have been tested for STIs.
- There was a general lack of data describing the proportion of children in need that receive services.

### **Analysis**

- Idaho should consider establishing school-based health centers to deliver health services to students. These centers increase access to medical homes among school-age children, can provide more effective care coordination and comprehensive services to children with chronic conditions, and help complement health education curriculums.
- The large number of ethnic and racial disparities in health risk behaviors highlights the need to develop a comprehensive strategy to address these disparities at the State level. In particular, a dedicated commitment to cultural competency is likely needed to effectively communicate health messages to at-risk population groups. In addition, many of these risk behaviors may go beyond health education and require interventions targeted at minority families.
- Without data describing rates of STI testing, it will not be possible to determine if the recent increase in rates is the result of an actual increase in new infections or an increase in the proportion of youth that got tested. In addition, to comprehensively evaluate adolescents' risk of STI infection, it will be necessary to begin collecting data regarding all types of sexual risk behaviors, especially the use of barrier protection.
- STI prevention efforts in Idaho appear to be very general and do not adequately focus on sexual behavior risks among adolescents. In particular, youth appear to be most at risk for STIs other than HIV, which has received the majority of attention.
- Existing program data is not as useful as it could be. The data needs to relate service utilization to the need for those services.

## **Adolescent children obtain the health and lifestyle information and education that support lifelong positive health behaviors.**

### **Summary**

- Only half of Idaho's middle and high schools currently requires students to receive at least one health education course.
- Nutrition and physical education have recently faced budget cuts in favor of a greater focus on basic education.
- Although most required health education courses do cover a broad range of topics, the majority of health education teachers have not received recent training on many of these health topics.
- There is a lack of data describing contraception and barrier protection use among sexually active youth.
- There are currently no statewide initiatives to address the high rate of unintentional injuries and associated risk behaviors in Idaho's youth

### **Analysis**

- Health education is an important component of adolescents' educational experience. Students who engage in risk behaviors are more likely to perform poorly in school and to miss school. Therefore, it is critical that school education teachers receive adequate support at the State level and be widely accessible to all students.
- Health education teachers need regular training to ensure that they provide students with the most accurate and up-to-date health information possible. Similarly, regular training also often provides teachers with the updates and more effective ways of communicating health education messages.
- It is important to collect data measuring the full range of health risk behaviors, including all sexual risk behaviors, to evaluate whether youth are internalizing health education messages.

## CHAPTER VIII

### CSHCN

---

#### Overview

The Maternal and Child Health Bureau (MCHB) defines CSHCN as: “children who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally” (McPherson, 1998). There is no agreement on an approach for identifying children who are at-risk under this definition, so most discussions of this population focus on children who have a condition and are in need of services. This represents a very broad population of children with a wide range of conditions and need for services.

Idaho CSHCN and their families receive services from a wide variety of agencies and providers. Some of the most important include Medicaid, the Infant Toddler Early Intervention Program, and Special Education services provided through local school districts. In addition to these agencies, the State Title V agency has a mandate to address the needs of CSHCN. The Title V Block Grant includes a provision requiring that 30 percent of the Federal Maternal and Child Health Block Grant be allocated for CSHCN. In Idaho this amounts to just over \$1 million of the Federal allocation. Historically BOCAPS has served a very limited portion of the statewide CSHCN population. Through the Children’s Special Health Program (CSHP), BOCAPS provides diagnostic, treatment, follow-up and case management services for children in eight general diagnostic categories. These categories are Cardiac, Cleft Lip and Palate, Craniofacial, Cystic Fibrosis, Neurological, Orthopedic, Phenylketonuria (PKU) and Plastic/Burn. Until October 2004, care was offered through clinics that brought together multiple providers to provide treatment and through case managers who coordinated treatment and care. Reimbursement was available for care not covered by other sources.

BOCAPs is now in the process of joining other State Title V agencies in transitioning from providing direct services to focusing on enabling services, infrastructure, and systems-building. As the cost of providing direct services was exceeding the available Title V funds, it was felt that many of the services could be provided through other means and paid for by Medicaid and private insurance. As of Fall 2004, Title V funds are no longer used to provide support for the CSHCN clinics, except for PKU and Cystic Fibrosis clinics. BOCAPS has made some initial decisions about what services are going to be provided, but has not fully developed a new strategy for addressing the needs of CSHCN. As of now, decisions have been made to fund direct and case management services for the uninsured portion of the low-income CSHCN population diagnosed within the 8 categories served under CSHP. Families with incomes higher than 185 percent of the Federal Poverty Level will continue to be assessed a co-payment for

CSHP services as they were under the old program. Case management services for this limited number of families are provided through a contract with Saint Luke's Regional Medical Center in Boise. The contract covers services provided by a single care coordinator. Other CSHCN families will be able to receive care coordination services through Medicaid and/or the Infant Toddler Program. This transition in services has been difficult, but it represents an opportunity to better serve a wider range of CSHCN than have traditionally received services through the Title V Program. BOCAPs and other agencies have the potential to develop a stronger system of services for CSHCN and their families. This section examines what is known about the CSHCN population in Idaho and the State's progress on achieving key outcomes for those families.

## A. Characteristics of the CSHCN Population

The National Survey of Children with Special Health Care Needs conducted in 2001 provides extensive data for children who fall under the broad definition of CSHCN. The survey was designed to obtain a representative sample of over 700 CSHCN children in each State. Because Idaho is a state with a small population, this represents a very robust sample and is an extremely rich data source.

As noted, the Federal definition of CSHCN that is used is very broad. It includes all children who have a functional limitation caused by a chronic health problem as well as those receiving medication or special services for a chronic health problem. This is a far broader population than that served by the CSHP Program and even goes beyond criteria used by more inclusive programs such as Special Education services. Children defined as CSHCN in the National Survey have a wide range of special needs and the level of severity of their problem varies greatly. The range of severity is shown by the answers to two questions about the nature of the child's condition. The results for these questions are shown in Table VIII-1.

<b>Table VIII-1. Severity of CSHCN Conditions</b>	
<b>Health Insurance Status</b>	<b>Percent</b>
Severity of Child's Condition or Problem	
Mild	28.2
Moderate	47.1
Severe	24.7
How much has child's condition affected child's ability to do things other children his or her age do?	
A great deal	21.7
Some	44.8
A very little	33.5

Source: Maternal and Child Health Bureau [MCHB], 2004

While the level of need for families varies, in order for these children to reach their maximum potential and for their families to best meet their needs, a support system needs to be in place. One way of gauging the different needs of such families is to examine what led the children to be classified as CSHCN. Children who are classified as CSHCN because they take medication differ in needs from those who are accessing services such as speech or occupational therapy, and from those who have developmental limitations that restrict their ability to engage in activities typical of other children their age. The percent of children in the different categories in Idaho is shown in Table VIII-2.

<b>Table VIII-2. Reason Child is Classified as a CSHCN</b>	
	<b>Percentage</b>
Receives Medication Only	28.3
Receives Special Therapy Only	20.8
Receives Both Medication and Special Therapy	23.4
Child has a Functional Limitation	27.5
Source: MCHB, 2004 Note: Children with functional limitations may or may not be receiving special therapy, medication, or both.	

In the National Survey of CSHCN there is a great deal of information available on the characteristics of CSHCN and their families. Table VIII-3 displays information on the characteristics of CSHCN in Idaho and the nation as a whole.

<b>Table VIII-3. Who Are the Children With Special Health Care Needs?</b>		
	<b>Idaho</b>	<b>United States</b>
Percentage of children and youth with special health care needs, 0-17 years old	11.5	12.8
Percentage of households with one or more CSHCN	18.6	20.0
Prevalence of special health care needs by age		
Children 0-5 years of age	6.0	7.8
Children 6-11 years of age	12.6	14.6
Children 12-17 years of age	15.7	15.8
Prevalence of special health care needs by sex		
Female	9.7	10.5
Male	13.3	15.0

<b>Table VIII-3. Who Are the Children With Special Health Care Needs?</b>		
	<b>Idaho</b>	<b>United States</b>
Prevalence by Race/Ethnicity		
Hispanic	5.8	8.5
White (non-Hispanic)	12.3	14.2
Black (non-Hispanic)	8.3	13.0
Prevalence by Poverty Level		
0-99 Percent of the Federal Poverty Level (FPL)	14.3	13.6
100-199 Percent of FPL	12.0	13.6
200-399 Percent of FPL	11.4	12.8
400 Percent of FPL	10.8	13.6

Source: MCHB, 2004

There is a somewhat lower percentage of CSHCN in Idaho than in the nation as a whole. This difference is accounted for by lower rates among younger children as the rate among children ages 12-17 is almost equal to the U.S. rate. Across the country, Hispanics are less likely to be identified as CSHCN and the difference between Hispanics and other racial/ethnic groups is even more pronounced in Idaho. Families who meet the Federal definition of poverty in Idaho are slightly more likely to have a CSCHN than those in the rest of the country, while families in all other income groups are less likely to have a CSHCN.

## **B. Outcomes for CSHCN Examined in the Needs Assessment**

There are four outcomes that have been selected for in-depth examination for Idaho's CSHCN population. Achieving these outcomes would go a long way to ensuring that CSHCN have the opportunity to reach their full potential and that their families are provided the support they need to raise their children to the best of their ability. In addition to these outcomes, the Federal Maternal and Child Health Bureau has developed 7 performance measures for CSHCN. These performance measures are included under the four needs assessment outcomes as shown in Table VIII-4.

Table VIII-4. Needs Assessment Outcomes and MCHB Performance Measures	
Needs Assessment Outcomes	MCHB Performance Measures
Children with chronic health problems or disabling conditions use all the primary and preventive services used by typical children.	None
CSHCN use the full range of health-related services needed to maintain their health and well-being and the services to slow, delay, or prevent untoward outcomes resulting from their chronic health conditions or disabilities.	Children will receive coordinated comprehensive care within a medical home.
Families of CSHCN, including their siblings, have access to and use appropriately the full range of health and health-related services required to promote their growth and well-being and manage their conditions or disabilities.	Families of CSHCN will partner in decision-making and will be satisfied with the services they receive.  Families of CSCHN will have adequate public and/or private insurance to pay for the services they need.  Community-based services systems will be organized so families can use them easily.
CSHCN use out of home childcare, preschool, and ongoing educational services as appropriate to their age, developmental stage, and health condition and/or disability.	Children will be screened early and continuously for special health care needs.  Youth with special health care needs will receive the services necessary to make transitions to adult life, including adult health care, work, and independence.

Source: Maternal and Child Health Bureau, 2005.

***Outcome 1: Children with chronic health problems or disabling conditions use all the primary and preventive services used by typical children.***

***Primary and Preventive Care Including Well-child Visits.*** Like typically developing children, CSHCN have a wide range of health care needs, including a need for basic primary and preventive care. Basic care helps insure early detection of health problems that might be neglected because of a focus on the condition that leads the child to be classified as CSHCN. In the National Survey of CSHCN, respondents were asked whether during the past 12 months their child “needed routine preventive care, such as a physical examination or well-child check-up.” In Idaho, only 64.7 percent of respondents reported that their CSHCN needed such care. This number is rather low and may indicate that parents of CSHCN, like parents of typical children, do not always realize the value of preventive care. This is especially apparent for parents of older children as shown in Table VIII-5 and for parents of Hispanic and non-white children as shown in Table VIII-6. Efforts to encourage the use of such care should recognize a need to target parents of both typical children and CSHCN.



<b>Table VIII-5. Percent of CSHCN Who Were Reported to Need Primary and Preventive Care by Age Group of Child</b>	
<b>Age Group of CSHCN</b>	<b>Percentage</b>
Age 0-5	80.5
Age 6-11	59.9
Age 12-17	63.4
All Children	64.7

Source: MCHB, 2004.

<b>Table VIII-6. Percent of CSHCN Who Were Reported to Need Primary and Preventive Care by Race/ethnicity of Child</b>	
<b>Race/ethnicity of CSHCN</b>	<b>Percentage</b>
White	66.5
Hispanic	52.2
Other	47.4
All Children	64.7

Source: MCHB, 2004.

Among those needing such care, the vast majority of families (95.4 percent) were able to obtain it. While the sample of those not obtaining care is very small, it is important to note that the most common reason given for not obtaining care (66.9 percent of those who did not receive care) was that it cost too much. (MCHB, 2004)

**Dental Care.** Adequate dental care is an important component of primary and preventive care. Families of CSHCN were more likely to report that they needed dental care, including checkups, than primary and preventive care (82.9 percent to 66.9 percent). As shown in Table VIII-7 the need for dental care increases with age, as very young children do not usually see a dentist. As was the case with primary care, Hispanic families were less likely to report needing a dentist. However, unlike primary care, there was little difference between white families and other race/ethnic groups in need for a dentist. (MCHB, 2004)

<b>Table VIII-7. Percent of CSHCN Who Were Reported to Need Dental Care by Age Group of Child</b>	
<b>Age Group of CSHCN</b>	<b>Percentage</b>
Age 0-5	61.0
Age 6-11	84.6
Age 12-17	88.9
All Children	82.9

Source: MCHB, 2004.

<b>Table VIII-8. Percent of CSHCN Who Reported a Need for Dental Care by Race/ethnicity of Child</b>	
<b>Race/ethnicity of CSHCN</b>	<b>Percentage</b>
White	83.8
Hispanic	68.5
Other	83.1
All Children	82.9

Source: MCHB, 2004.

Most of those CSHCN who say they need dental care were able to obtain it (88.5 percent). Similar to primary care, the most common reason for not obtaining it was that it cost too much (cited by 50.8 percent of those unable to obtain it) (MCHB, 2004). However, these data may underestimate the percent of those CSHCN who are not obtaining needed dental care. There is a clear association between income and type of insurance and whether a family indicates they need dental care as shown in Table VIII-9. This finding may partially reflect different views of the type of care children need in different cultures or among those with different levels of education. However, it is also possible that some families know they will have difficulty accessing care because of cost or because of a lack of providers who accept their insurance, and thus they are less likely to seek care unless the child has a more serious problem.

<b>Table VIII-9.</b> <b>Percentage of Respondents Indicating CSHCN</b> <b>Needed Dental Services in the Past Year</b>	
Income	
0-99 Percent of the Federal Poverty Level (FPL)	74.4
100-199 Percent of FPL	79.6
200-399 Percent of FPL	86.0
400 Percent of FPL	95.2
Insurance Type	
Private Insurance Only	86.8
Public Insurance	77.9
Private and Public Insurance	81.0
Uninsured	72.5

Source: MCHB, 2004.

***Eyeglasses and Vision Care.*** Finally, eyeglasses and vision care is another category of primary and preventive care that children sometimes need. Overall, 36.5 percent of CSHCN needed such care in the 12 months prior to the survey. The vast majority (96.4 percent) in need of this care received it (MCHB, 2004). There was little difference in terms of identifying a need for eyeglasses or other vision care across income groups. However, as shown in Table VIII-10, Hispanics were more likely than other groups to identify a need for eyeglasses or vision care. This difference is relatively small and may be a product of the relatively small size of the Hispanic sample rather than a real difference.

<b>Table VIII-10.</b> <b>Percent of CSHCN Who Were Reported a</b> <b>Need for Eyeglasses or Vision Care</b>	
<b>Race/ethnicity of CSHCN</b>	<b>Percentage</b>
White	36.2
Hispanic	44.1
Other	32.7
All Children	36.5

Source: MCHB, 2004.

***Outcome 2: CSHCN use the full range of health-related services needed to maintain their health and well-being and the services to slow, delay, or prevent untoward outcomes resulting from their chronic health conditions or disabilities.***

***Types of Care Needed and Used.*** Other than primary care what types of health care do CSHCN need and use? The National Survey of CSHCN asked respondents whether their children needed a wide range of services in the past year and whether they were able to obtain them. The results are shown in Table VIII-11. The service that most families needed was prescription drugs, followed by care from a specialty doctor; medical supplies; physical, occupational or speech therapy; and mental health care or counseling. In all cases most families who said they needed a service were able to obtain them. The services that families found the hardest to obtain were genetic counseling and mental health care.

<b>Table VIII-11. Types of Care Needed and Received by CSHCN</b>		
<b>Type of Care</b>	<b>Percentage Needing Care</b>	<b>Percentage of Those Needing Care Who Received It</b>
Prescription Medicines	86.1	98.0
Care From a Specialty Doctor	53.8	90.5
Medical Supplies	26.3	98.6
Physical, Occupational or Speech Therapy	23.9	91.7
Mental Health Care or Counseling	15.4	75.2
Hearing Aids or Care	7.8	94.8
Genetic Counseling	6.3	76.9
Home Health Care	5.3	97.3

Source: MCHB, 2004.

Table VIII-12 examines some of the reasons CSHCN were unable to obtain different types of care. With the exception of genetic counseling, the most common reason that families of CSHCN were unable to obtain care for each type of care was that it cost too much. The most common reason for not obtaining genetic counseling was that it unavailable in the area.<sup>1</sup> Thus out-of-pocket costs represent barrier to services for quite a few families of CSHCN. Problems with health plans were a factor in preventing families from obtaining medical specialty care, but were a problem for over one-quarter of families unable to obtain physical, occupational or speech therapy and for just over 17 percent of those unable to obtain mental health care or

<sup>1</sup> However, it should be noted that there were too few cases of families who needed, but could not obtain, genetic counseling that the difference between those saying it cost too much and those saying it was unavailable to assess statistical differences.

counseling. This suggests families may need assistance obtaining these types of care either through their insurance or from another source. Finally in regard to mental health care, both key informants and recent Department of Health and Welfare reports and plans mention a shortage of mental health providers for children. This shortage is reflected in the percentage of respondents reporting having difficulties finding providers in the area who are available at convenient times.

<b>Table VIII-12. Reasons Unable to Obtain Needed Care for CSHCN by Type of Care</b>				
<b>Type of Care</b>	<b>Reasons Unable to Obtain Needed Care</b>			
	<b>Cost too much</b>	<b>Problem with health plan</b>	<b>Not available in area or transportation problems</b>	<b>Times service was available was not convenient</b>
Care From a Specialty Doctor	32.1	4.3	14.1	3.1
Physical, Occupational or Speech Therapy	42.5	26.2	4.6	0
Mental Health Care or Counseling	45.1	17.3	15.1	21.4
Genetic Counseling	19.8	0	24.0	0

Source: MCHB, 2004.

While most families who needed specialty care were able to obtain it, the process of accessing that care was not always easy. Almost 18 percent of families reported a problem obtaining a referral as shown in Table VIII-13. This was more likely for families with CSHCN with more severe problems. Part of this difference is likely accounted for by a need for a greater number of referrals for these families.

<b>Table VIII-13. How Often Did a Family Report a Problem Getting a Referral by Severity of Child's Condition</b>	
<b>Severity of CSHCN Condition</b>	<b>Percentage Reporting a Problem Getting a Referral to See a Specialist</b>
All Children	17.9
Mild Severity	7.4
Moderate Severity	15.8
Severe	34.3

Source: MCHB, 2004.

Families who receive Medicaid were more likely to have reported a problem with obtaining a referral as shown in Table VIII-14. A number of things could account for this difference. A

higher percentage of families that use Medicaid report a child with serious conditions and these families may use more specialists and report more problems obtaining specialist care. Also, families with CSHCN in the focus groups indicated that Healthy Connections, the Medicaid managed care program, added an extra step in obtaining specialty care. These parents had to visit their primary care provider (PCP) to obtain a referral even though their child's condition was so serious that the PCP had very limited involvement and understanding of their child's medical situation. Most focus group participants said their PCP agreed to give them referrals without a problem, but they found the extra step of an additional doctor's office visit to be burdensome. It should be noted that this added step is probably not achieving Healthy Connections cost containment goal. If, as parents indicate, PCPs do not feel like they know enough about the care requested to deny it, they also do not know enough to assess whether it is medically necessary. Given the burden it imposes and its limited utility, Medicaid may want to assess whether Healthy Connections is appropriate for children with more severe disabilities.

<b>Table VIII-14. How Often Did a Family Report a Problem Getting a Referral by Type of Insurance</b>	
<b>Type of Insurance</b>	<b>Percentage Reporting a Problem Getting a Referral to See a Specialist</b>
Public Insurance	27.3
Both Public and Private Insurance	26.9
Private Insurance Only	12.8

Source: MCHB, 2004.

***Medical Home and Access to Coordinated Care.*** MCHB has established a goal of having CSHCN receive coordinated comprehensive care through a medical home. Care provided through a medical home should be continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. Under the outcome being discussed in this section, we will explore the extent to which a family receives care from a provider with characteristics of a medical home and the extent to which that care is coordinated. Discussions about the extent that care is family centered are under the next outcome.

One of the features of a medical home is that children receive care from a single provider who knows them. As shown in Table VIII-15, the vast majority of CSHCN have a usual source for care. Most also have someone who is identified as the child's personal doctor or nurse who knows the child best. The Hispanic population is somewhat less likely to be able to identify a usual source of care (74.2 percent) and a personal doctor or nurse who knows their child best (76.7 percent). Over 90 percent of non-Hispanic white families identify a usual source of care, and almost as many (88.2 percent) can identify a personal doctor or nurse for their child. (MCHB, 2004.)

<b>Table VIII-15. Medical Home Indicators: Usual Providers</b>	
CSHCN has a usual source of care	90.2%
CSHCN has a personal doctor or nurse who knows them well	87.6%

Source: MCHB, 2004.

In addition to having a usual source of care it is important that doctors communicate well with other doctors and other programs. As shown in Table VIII-16, doctor's who are excellent or very good at communicating with other doctors are the exception rather than the rule. There are even fewer doctors who are very successful at communicating with other programs. While the numbers for Idaho are not significantly different than in other parts of the country, communication between providers is an important part of a successful medical home. In the Idaho Families of CSHCN Survey, over 85 percent of respondents said it was very important to have a care coordinator available who can coordinate communication between doctors, hospitals, and therapists. This was even higher than the 77 percent who thought care coordination of medical care was very important (Please see Appendix B for more information about this survey). Given the importance of communication and the medical community's shortcomings in this area, efforts are needed to strengthen communication and to develop tools that help providers share information allowing them to better serve children and families.

<b>Table VIII-16. Medical Home Indicators: Communication with Other Providers</b>	
Doctors communicated well with each other (respondents who replied excellent or very good)	48.3%
Doctors communicated well with other programs (respondents who replied excellent or very good)	37.1%

Source: MCHB, 2004.

For many families of CSHCN, access to care coordination is an important component of health care. Care coordination is also a key feature in a medical home. Children may have multiple providers and it is important to have someone who can coordinate services and find additional services when needed. While experts stress the importance of care coordination, it is not clear that parents see things in quite the same way. In the National Survey of CSHCN, only 15.6 percent of Idaho parents of CSHCN reported that their child needed professional care coordination in the past year. This low number may reflect the way respondents defined care coordination or professional care coordinator. It may be that parents have not used care coordination or have had negative experiences so they do not see it as a need. (MCHB, 2004.)

As shown in Table VIII-17 data from the National Survey of CSHCN indicate that care coordination is more frequent for families on public insurance than those on private insurance. This is consistent with findings from the focus groups where families spoke about the lack of care coordination from private insurance plans. Those with private plans generally said they were on their own in terms of arranging care and making connections with providers.

<b>Table VIII-17. How Often Does a Professional Help Coordinate Child's Care by Type of Insurance Among Those Needing Professional Care Coordination</b>	
<b>Type of Insurance</b>	<b>Percentage Reporting That a Professional Usually or Always Coordinates Their Child's Care</b>
All Children	32.5
Public Insurance	40.5
Both Public and Private Insurance	34.3
Private Insurance Only	23.5

Source: MCHB, 2004.

The Idaho Families of Children with Special Health Care Needs Survey reported a much higher rate of care coordination usage. Nearly three quarters of parents who responded reported they used care coordination services in 2004. Medicaid was cited as the source of care coordination by most of those who received it, followed by the Infant Toddler Program, CSHP, and private care coordination companies. The discrepancy between the National Survey and the Idaho Survey likely is a result of the surveys drawing from a different pool of respondents. Most of the respondents to the Idaho Survey heard or received the survey through programs that their children participate in. These parents were more likely to have children with more serious conditions and more likely to be connected to services such as care coordination than those identified in the National Survey. Over 90 percent of parents in the Idaho survey said that it was very important for families of CSHCN to have information about what care coordination services are available and how to obtain those services.

<b>Table VIII-18. Care Coordination Use</b>	
	Percentage
Received Care Coordination	73.8%
Program or Agency Providing Care Coordination Among Those Who Received it	
Medicaid	43.0%
Infant Toddler Program	39.2%
CSHP	27.8%
Private Care Coordination Company	21.5%
Private Insurance	8.9%

Source: Idaho Families of Children with Special Health Care Needs Survey

Parents of CSHCN in the focus groups had mixed feelings about care coordination. They expressed a clear need for care coordination services, but had very mixed experiences with care coordinators. Many of them reported positive experiences with care coordination from the Infant



Toddler and CSHP Program, but experiences with Medicaid care coordinators were more mixed. A number of parents were unclear on what services these coordinators were supposed to provide. Some parents indicated that they did not find their advice useful and did not find them respectful so they stopped using their services.

**CSHP Program.** Many CSHCN with some of the most serious health conditions have been receiving some of their medical care through the Children's Special Health Program (CSHP). As noted earlier, CSHP has provided services to children with a limited number of conditions. Care has been provided through clinics that brought together multiple providers to provide treatment. The CSHP Program staff indicated that approximately 2,500-2,700 had been enrolled in the program and were eligible for care coordination services, treatment at the CSHP clinics, and reimbursement for services not covered by other sources. These numbers included an estimated 300 children who are uninsured and will be eligible for services under the new more limited CSHP Program. Table VIII-19 shows the number of children treated at clinics and by outside sources funded by CSHP in the year 2003. Data on who was receiving care coordination services was not available from the District Health Departments, but program enrollees who did not attend clinics could receive care coordination. In 2003, CSHP spent a little over \$224,000 on outside services for CSHCN. The costs of running the clinics included about \$600,000 in contract costs with local health districts and \$200,000 to reimburse doctors for travel and labor.

<b>Table VIII-19. CSHP Program Usage, 2003</b>		
<b>Condition</b>	<b>Children Treated at CSHP Clinic</b>	<b>Children With Outside Services Paid for By CSHP</b>
Cardiac	378	122
Cleft Lip and Palate	137	52
Craniofacial	49	22
Cystic Fibrosis	0	8
Neurological	63	41
Orthopedic	231	40
Phenylketonuria (PKU)	0	1
Plastic/Burn	0	6

Source: Idaho CSHP, 2004.

Most of the clinics operated by CSHP will continue under different auspices and many of the services previously funded under CSHP will be paid for under Medicaid for those families who qualify. However, this still remains a difficult transition. Because CSHP was available to cover services not covered under private insurance, the out-of-pocket expenses for parents who do not qualify for Medicaid may increase substantially. Both in the survey and the focus groups some

parents indicated that they had limited insurance coverage for their CSHCN because of the cost or because of plan limits. Additional out-of-pocket costs will be very difficult for many families to handle.

In addition, parents of CSHCN who participated in focus groups are concerned that the new clinics will not provide the same comprehensive care they received previously. Parents felt that the Health Districts did an excellent job organizing these clinics and are concerned that private providers will not be able to match that effort. Both parents and key informants from District Health Departments worried whether private providers would be willing to maintain the clinics over the long run.

Parents were also worried that while the medical care may still be available, the support services were likely to be more limited and care coordination will suffer. Part of this concern stems from mixed feelings about the quality of care coordination that is provided under Medicaid. While some parents had good things to say about the contracted care coordinators provided for their children under Medicaid, other parents reported very negative experiences. Care coordinators' experience with addressing the needs of the CSHCN population varied and it was not easy for parents to identify coordinators who were best suited for special needs children. It was not clear that all parents eligible even understand that they can obtain Medicaid care coordination services. Not all parents were given enough information to make informed choices about engaging a contracted care coordinator. There is a need for BOCAPs and Medicaid to examine this process and work to develop educational materials for parents and standards for care coordinators who are serving the CSHCN population. Medicaid staff agreed that consumer education on care coordination was needed, but the impetus for making progress in this area may need to come from another agency such as BOCAPs or the Division of Disabilities. Unfortunately, the Division of Disabilities has been given extremely limited resources for fulfilling their responsibility of quality assurance for care coordination.

***Outcome 3: Families of CSHCN, including their siblings, have access to and use appropriately the full range of health and health-related services required to promote their growth and well-being and manage their conditions or disabilities.***

Families of CSHCN need to be able to access a range of services without there being too high of a cost in terms of financial well-being and emotional strain.

***Access to Quality Insurance Coverage.*** Families of CSHCN with high quality insurance coverage are able to access care with less strain on family finances. One of the MCHB Title V performance measures is that families of CSHCN will have adequate private and/or public insurance to pay for the services they need. As shown in Table VIII-20, the vast majority of Idaho CSHCN have some type of health insurance. The percent of uninsured children was only slightly higher than the 5.2 percent estimate for the country as a whole. In addition, to those who were uninsured at the time of the interview, an additional 6.4 percent of CSHCN experienced some gap in coverage during the year prior to the interview (MCHB, 2004). For parents of CSHCN, a gap in coverage can be an especially serious problem, because if it comes at a time when a child needs immediate care the family may find itself incurring extraordinary expenses.

The costs are likely to be high enough that the family may find itself in long-term debt with serious long-term impacts on the family's wellbeing.

<b>Table VIII-20. Insurance Coverage for Idaho CSHCN</b>	
<b>Health Insurance Status</b>	<b>Percent</b>
Type of Health Insurance for CSHCN	
Private insurance only	56.0
Public insurance	27.6
Both private and public insurance	10.3
Uninsured	6.2
Percent of CSHCN With No Gap in Coverage During the Year Prior to the Interview	87.4

Source: MCHB, 2004

Hispanics are the most likely of any racial/ethnic group to be uninsured at the time of the survey. Hispanics and those classified as "Other race/ethnicity" were more likely to rely on public insurance, though more than one-third of Whites either have public insurance alone or in combination with private insurance. Medicaid and SCHIP are crucial resources for families of CSHCN, and the quality of services they provide are critical in achieving positive outcomes for these families. While their relatively low incomes are probably one cause of the lack of insurance among Hispanic families, another possibility is that eligible Hispanic families are not applying because they do not understand the eligibility rules. Hispanic immigrant parents may not realize that their U.S.-born children may be eligible regardless of their own citizenship status.

In the Idaho Families of Children with Special Health Care Needs Survey over 90 percent of respondents indicated that it was very important for families of CSHCN to have information about how to apply for Medicaid and what benefits are covered under Medicaid. While the 'other race/ethnicity' group was not more likely than Whites to be uninsured at the time of the survey, they did not report a high rate of uninsurance over the course of the year. The small sample size of uninsured 'other race/ethnicity' families made assessments of coverage in this group impossible. However, this small sample size does raise some concern that people may be coming on and off Medicaid and SCHIP on a regular basis and thus experiencing periods without coverage.

The poorest families were not the most vulnerable due to a lack of insurance. Families just above the poverty level were three times as likely as those under the poverty level to be uninsured. Almost one-quarter of these families were uninsured at some point during the 12 months prior to the survey (MCHB, 2004). These families almost always include at least one working adult and are struggling to play by the rules, but are denied access to a critical resource.

<b>Table VIII-21. Insurance Coverage by Race/Ethnicity and Income</b>					
<b>Characteristic</b>	<b>Insurance Status</b>				
	<b>Private</b>	<b>Public</b>	<b>Both Public and Private</b>	<b>Uninsured at the time of survey</b>	<b>Uninsured during past 12 months</b>
<b>Race/ethnicity</b>					
White	58.3	25.6	10.6	5.4	10.6
Hispanic	38.3	40.2	3.5	18.0	27.5
Other	35.0	47.2	11.4	6.4	30.9
<b>Income</b>					
0-99 percent of the Federal Poverty Level (FPL)	11.1	75.0	9.9	4.0	13.0
100-199 percent of FPL	39.3	38.9	9.7	12.2	23.7
200-399 percent of FPL	80.0	5.8	10.4	3.9	7.8
400 percent of FPL	88.7	1.4	9.2	0.8	2.4

Source: MCHB, 2004

Respondents were asked whether their insurance was meeting their child's needs. While most respondents reported that their insurance coverage was meeting their child's needs, there were quite a few respondents for whom this was not the case. One of the biggest challenges faced by parents was the cost of care not covered by insurance. About one-third of respondents reported that these costs were never or only sometimes reasonable.

<b>Table VIII-22. Adequacy of Insurance Coverage for Idaho CSHCN</b>	
<b>Characteristic of Insurance Coverage</b>	<b>Percent of Insured Children</b>
Insurance usually or always met child's needs	84.2
Insurance usually or always permitted child to see needed providers	85.4
Costs not covered by insurance were usually or always reasonable	66.4

Source: MCHB, 2004

The type of insurance did not make a difference in whether health insurance usually or always met child's needs, but participants on Medicaid were more likely to characterize their health plan

as good for CSHCN. Participants in the focus groups indicated that some of the strong points of Medicaid were low out-of-pocket costs and more assistance with care coordination than private insurance.

<b>Table VIII-23.</b>			
<b>Type of Insurance by Adequacy of Insurance</b>			
<b>Adequacy of Insurance</b>	<b>Type of Insurance</b>		
	<b>Private Insurance</b>	<b>Public Insurance</b>	<b>Both Private and Public Insurance</b>
Percent indicating insurance usually or always met child's needs	83.8	85.0	87.0
Percent indicating insurance is good for CSHCN	71.8	89.0	90.4

Source: MCHB, 2004

While there are a number of positive aspects of having Medicaid for CSHCN, there are also some important challenges that families face in accessing and using Medicaid. In the Idaho Families of CSHCN survey 34.9 percent of families reported that they needed more information about what services were covered under Medicaid, while another 22 percent reported that they needed much more information about this. This topic came up during the focus groups with parents reporting that it was often unclear what services and equipment were covered and it was difficult to obtain a direct answer on these issues from the Medicaid office.

Parents of CSHCN in the focus groups described great difficulty finding out about, applying for, and maintaining benefits under the Katie Beckett provisions of Medicaid. Katie Beckett Medicaid is available to families who, if they did not have Medicaid, would have to put their child in residential care because the child requires costly in-home care. Because the child would be living outside the home without Medicaid, the child's income and assets are counted when determining eligibility rather than the other household members. Quite a few parents reported that Medicaid eligibility workers were unaware of the rules for Katie Beckett Medicaid and were unable to assist them with applying. Parents reported a great fear of losing Medicaid when it came time to reapply because of administrative reasons or because of slight changes in their child's condition. One parent of a foster-child with special needs indicated that her family maintained burdensomely expensive catastrophic health care coverage for the child because she had been told that a change in the child's condition could possibly result in them losing Katie Beckett Medicaid coverage. Other families reported losing coverage because of what appeared to be administrative problems. The result of these problems is that families are under tremendous strain, feel financially vulnerable, and do not feel the system exists to help them. Medicaid could alleviate some of these problems by training specific workers or supervisors to specialize in these cases. The laws and regulations governing Katie Beckett Medicaid are indeed complex and it may not be reasonable or efficient to expect all eligibility workers to be able to apply them. However, in order to provide a reasonable level of customer service and support for families in difficult circumstances, it would be useful to have workers specifically trained to handle these cases in regional and State administrative offices.

**Financial Strain.** Having a child with special needs is often a considerable financial burden that strains a family's resources and creates additional stress. More than one-quarter (27.6 percent) of families of CSHCN report that their child's condition has caused financial problems for the family (MCHB, 2004). The financial burden differs by the level of severity of the child's illness as shown in Table VIII-24.

<b>Table VIII-24.</b> <b>Percent of Respondents Indicating that their Child's Condition has Caused Financial Problems for Their Family by Severity of Child's Condition</b>	
<b>Severity of Child's Condition</b>	<b>Percentage Reporting Financial Problems</b>
Mild	15.8
Moderate	28.1
Severe	40.5

Source: MCHB, 2004

The parents of CSHCN who participated in the focus groups elaborated on the financial burdens they face. Many of those with private insurance had to contribute substantial co-payments in order to provide for their children. Others indicated that there had been a time when they were without insurance and that they have never been able to fully recover financially. A number of them described being pursued by debt collection agencies. Parents in these groups have varying knowledge about how the health system works and while some reported that they were able to convince hospital billing departments that their debt should at least be partially written off as charity care, others were unaware that such a possibility existed. While it is impossible to fully alleviate the strain of raising a child with special needs, efforts to organize services and ensure access to available benefits with minimal hassle can help limit the stress on the family. Having someone available who can discuss options when financial burdens become too great would also be helpful.

**Family-centered Care.** Another MCHB Title V outcome is that families of CSHCN partner in decision-making and are satisfied with the care they receive. There are a number of questions on the National Survey of CSHCN which address whether doctors delivered family-centered care. The results shown in Table VIII-25 generally indicate that most families report positive experiences with their doctors.

<b>Table VIII-25.</b> <b>Indicators of Family Centered Care</b>	
Doctors usually or always spent enough time	84.4%
Doctors usually or always listened carefully	87.0%
Doctors were usually or always sensitive to values and customs	85.9%
Doctors usually or always provided needed information	80.5%

Source: National Survey of CSHCN

Hispanics were less likely than Whites or those of other races/ethnicities to agree that doctors usually or always provide family-centered care. This may be because doctors who provide services to the Hispanic community are more in demand and have less time for individual patients, or it may be that some doctors have failed to develop culturally sensitive practices.

<b>Table VIII-26.</b>			
<b>Indicators of Family Centered Care By Race/Ethnicity</b>			
<b>Indicator</b>	<b>Race/Ethnicity</b>		
	<b>White</b>	<b>Hispanic</b>	<b>Other</b>
Doctors usually or always spent enough time	86.2	66.8	71.7
Doctors usually or always listened carefully	87.7	79.9	81.2
Doctors were usually or always sensitive to values and customs	86.5	75.7	86.2
Doctors usually or always provided needed information	81.1	67.3	77.8

Source: MCHB, 2004

In general, families of CSHCN in the focus groups were usually satisfied with the medical care they received. Some of them did report negative experiences with doctors or health care professionals who questioned why they were investing so much energy in what the professional saw as a helpless case. But overall the quality of care, especially that provided by specialists, did not seem to be the big concern. What was far less family-centered was the ability to obtain approval for care, especially non-medical services such as physical and occupational therapy.

**Community-based Services for Families of CSHCN.** Another Title V performance measure is that community-based service systems will be organized so that families can use them easily. Three-quarters of respondents to the National Survey of CSHCN reported that community-based services were usually or always organized so that families can easily use them (MCHB, 2004).

This relatively positive perception contrasts with the views of parents of CSHCN who took part in the focus groups. These families reported an almost complete lack of supportive services for families of CSHCN. These families are under tremendous stress, but lack access to assistance to relieve the strain. Families indicated that respite care benefits were inadequate and that it was very difficult to find anyone to watch special needs children for the amount that is paid. Transportation reimbursements of \$0.10 per mile do not nearly cover costs. The process of obtaining reimbursement was considered burdensome and further discouraged parents from utilizing this resource. There needs to be recognition that these families spend tremendous amounts of time seeking and managing care for their children. When unnecessary difficulties are created in obtaining assistance, they must weigh the costs in additional time with their other obligations. Other families, especially those who delivered special needs children in Salt Lake City, reported that when they had their special needs child they were simply not given enough information about what was available and what they needed to do once they arrived home. While it was helpful to have been given the number for the Infant Toddler Program, it would have been more helpful to have been given a better sense that they would have some support available once the child arrived home. In the Idaho Families of CSHCN survey almost 93

percent of families cited access to ongoing up-to-date information about programs, services and eligibility as a very important support service. Families in the focus groups indicated that it was more of a struggle to obtain information on what was available and what needs to be done to access services than it should be.

Parents did identify a few places where they were able to find positive support and information. St. Luke's in Boise offered a wide range of supportive services along with access to parent support groups for families whose children are hospitalized. A few of the parents had developed their own support groups while some relied on internet-based support groups for children with conditions similar to theirs. Parent groups are able to provide a level of support and information that is otherwise lacking. Even during the focus groups, parents were updating each other on changes in programs and providing suggestions for finding services. One way the MCH agency can fulfill its mandate to help the CSHCN population is to provide support to encourage the creation of parent groups and the training of parents as peer advocates who can work with other families with CSHCN. Most parents who received services from the Infant Toddler Program reported positive experiences with those services. This also is the program that is cited as being most open to parental input and participation. It is likely that these two findings are linked and that other programs need to make similar efforts to welcome parent participation in program development and service delivery.

***Outcome 4: CSHCN use out of home childcare, preschool, and ongoing educational services as appropriate to their age, developmental stage, and health condition and/or disability.***

The needs of CSHCN change throughout their lifetime and it is important they have access to services that foster their development. There are a number of agencies that have lead responsibility for providing these services; connections between these agencies and other providers are essential to ensuring that CSHCN have access to early education and development services.

***Inclusive Child Care.*** Like all families, families of CSHCN often need child care services. However, families of CSHCN face extra challenges in finding a qualified and affordable provider. The Idaho Department of Health and Welfare recognizes that there are very limited child care options for CSHCN. The Department commissioned a paper from the Center on Disabilities and Human Development (CDHC) at the University of Idaho to look at options for Promoting Inclusive Child Care in Idaho. The subsidies offered by the Idaho Child Care Program are clearly inadequate for CSHCN. While some children participate in Infant Toddler or pre-school special education programs, these tend to only be for a few hours each day. Children may receive Medicaid-funded developmental therapy services from a Developmental Disabilities Agency (DDA) Provider, but these services are not generally provided at child care settings (Center on Disabilities and Human Development, 2004). The Idaho Child Care Program, the Division of Medicaid, CDHC and the Idaho Association for the Education of Young Children (IAEYC) have formed a task force to discuss options for improving access to child care, including ways to make it easier for child care providers to qualify as DDAs and thus obtain reimbursement for providing developmental therapy.



***The Infant Toddler Early Intervention Program.*** The Infant Toddler Early Intervention Program appears to provide a good start for CSHCN who are identified in the first three years of life. Focus group participants and key informants generally had a good impression of the program. Some focus group participants expressed regret over the change from center-based to natural environment settings for care. Parents of older children reported positive experiences in Infant Toddler centers and these centers also offered a setting where parents of CSHCN could connect with each other. However, regardless of these concerns, most parents reported positive experiences with the care coordination and other services offered through the Infant Toddler Program. The Regional Interagency Coordinating Councils were reported to be a positive source of collaboration and the program was credited with welcoming parent involvement.

The “child find” function, which involves trying to identify children eligible for the Infant Toddler Program, is formally the responsibility of the Health District offices. However, focus groups and key informant interviews indicated that other organizations such as Head Start also conduct developmental assessments. A number of parents in the focus groups which included mostly parents of typical children felt that these assessments were not well publicized and their purpose was not always explained. The Infant Toddler Program is also responsible for the Developmental Monitoring Program. This is another effort to identify children in need of services. Parents are sent copies of the Ages and Stages Questionnaire (ASQ) and the completed forms are reviewed by the Health District offices. The District offices are responsible for making referrals when warranted. The Program Director reported that 5,500 ASQs are sent out annually under this initiative. There is not enough information to judge the success of this effort on a statewide basis, however concerns were raised by parents in District 2 because the questionnaires were arriving late and were no longer appropriate for the age of the child in the household. On the other hand, it was also reported that the wide distribution of the ASQ has served to educate parents and providers about what constitutes developmentally appropriate behavior. This may result in increases in self-referrals.

Key informants indicated that educating physicians and hospitals to make referrals into the infant and toddler program is a challenge. Physicians are currently responsible for about 18 percent of referrals, hospitals 17 percent, family and friends 25 percent, public health facilities 20 percent and other social services approximately 7 percent. On the state level, a few years ago the Infant Toddler program engaged in a blitz of training activity for physicians and saw an increase in referrals from physicians. However, the numbers have decreased again. In Pocatello, a Children’s Special Health Program Task Force was formed with partners including the District Health Department, the Regional Health and Welfare Office, two regional medical centers, Idaho State University, and Idaho Parents Unlimited, a parent advocacy organization. One of the goals was to identify and refer children for needed services. As a result of this effort the percent of referrals from primary care physicians rose from 16 percent to 26 percent. (Early Intervention Research Institute, 2001). These experiences clearly indicate that physician behavior can be changed, but that ongoing efforts are needed to reinforce the changes.

Once a child is identified they can receive a wide array of services under the Infant Toddler Program. On June 1, 2004, the Infant Toddler Program was serving 320 children ages birth to one and 1,576 children ages birth-3. The target goal is to enroll at least 1 percent of all children ages birth to one and 2 percent of children ages birth to three. Overall the State is meeting those targets, though at various points some regions have struggled to achieve them. Region IV, which

includes Boise, was not meeting the target for infants and over the last few years has regularly failed to meet the 2 percent target for all eligible age groups. In fact, the available data which goes back to 1998 shows that June 2004 was the first time they had met the 2 percent target. The Part C Annual Performance Report attributes this to rapid population growth in the region, combined with staff shortages that limit the extent of outreach and child find activities.

<b>Table VIII-27. Enrollment in the Infant Toddler Program by Age Group and Region, June 1, 2004</b>		
<b>Region</b>	<b>Age Group</b>	
	<b>Birth-1</b>	<b>Birth-3</b>
Region 1	1.26	2.25
Region II	1.93	2.82
Region III	2.05	2.89
Region IV	0.92	2.05
Region V	2.43	3.04
Region VI	1.13	2.76
Region VII	1.63	2.49
State	1.53	2.49

Source: Idaho Infant and Toddler Program, 2004.

Another possible source of under-participation in the Infant Toddler Program in Region IV is apparent from an examination of enrollment data by race and ethnicity. As shown in Table X-27, for most regions the percent of Hispanics enrolled in the program is higher than the percent in the population. This is to be expected since Hispanic families in Idaho exhibit more risk factors, such as poverty and lack of health insurance. However, in Region IV, the share of Hispanic enrollment is equal to the share of the Hispanic population of the region. Another area of concern is Region I, which has a lower share of both Hispanics and American Indians enrolled than might be expected given the two groups share of the population in these regions. Similarly, Regions 3 and 5 also have low enrollment for the American Indian population, especially in relation to Region II. While it is impossible to say what the ideal proportion of each population group should be enrolled in the Infant Toddler Program, the discrepancies between regions suggest an area that warrants further investigation. Some regions may have developed very successful outreach and child find efforts with specific populations that can be shared with others. It is very important that all agencies and organizations come together to ensure that children in this age group in need of services obtain those services because this may help head off future problems.

<b>Table VIII-28.</b> <b>Enrollment in Infant Toddler Program by Race/ethnicity and Region</b> <b>“Cumulative” Count Data for Program Participants, May 31, 2003 thru June 1, 2004</b>						
Region	White		Hispanic		American Indian	
	Percent Enrolled	Percent of Population	Percent Enrolled	Percent of Population	Percent Enrolled	Percent of Population
Region 1	98.2	97.3	0.7	2.3	0.7	1.9
Region II	82.9	94.8	2.1	2.0	13.4	3.4
Region III	68.3	97.0	30.4	17.7	0.2	1.3
Region IV	89.8	95.5	5.6	5.6	0.5	0.9
Region V	75.2	97.9	23.6	15.7	0	1.0
Region VI	83.4	94.8	11.0	8.0	3.7	3.8
Region VII	82.1	97.9	14.7	7.5	1.1	0.7
State	81.9	96.4	14.4	8.5	1.8	1.6

Source: Idaho Infant and Toddler Program, 2004.

There are data that raise some interesting questions about collaboration between the Infant Toddler Program and other programs that serve CSHCN. As shown in Table VIII-29, there are vast differences in the percent of children enrolled in the Infant Toddler program who also participated in the CSHP program and who are involved with the Bureau of Children and Family Services or child protection agency. It is possible that some of these differences may reflect differences in data collection efforts in the regions, but regardless of data issues they also likely reflect regional differences in the level of collaboration between programs.

<b>Table VIII-29.</b> <b>Enrollment in the Infant Toddler Program by Involvement With Other Programs and Region, May 31, 2003 thru June 1, 2004</b>		
Region	Other Program Involvement	
	CSHP Enrolled	CFS Enrolled
Region 1	2.9%	6.8%
Region II	2.1%	36.1%
Region III	1.1%	11.4%
Region IV	4.9%	5.4%

<b>Table VIII-29. Enrollment in the Infant Toddler Program by Involvement With Other Programs and Region, May 31, 2003 thru June 1, 2004</b>		
<b>Region</b>	<b>Other Program Involvement</b>	
	<b>CSHP Enrolled</b>	<b>CFS Enrolled</b>
Region V	8.3%	12.7%
Region VI	7.2%	9.1%
Region VII	16.6%	6.0%
State	6.4%	9.5%

Source: Idaho Infant and Toddler Program, 2004.

Collaboration between the Infant Toddler Program and the Bureau of Children and Family Services will be of increasing importance. As a result of changes in Federal regulations, the Infant Toddler Program will need to begin doing a developmental assessment on all children where there is a substantiated case of abuse or neglect. Implementation of this provision is a major challenge for program staff who have not generally been responsible for conducting mandatory assessments. In addition, adding additional responsibilities in the face of limited staffing is a real concern. Ideally, child protection workers can be trained to conduct developmental assessments, but at this point in time responsibility will be in the hands of Infant Toddler Program staff.

**Special Education Services.** At age 3 children who have disabilities or delays are no longer eligible for the Infant Toddler Program. They may qualify for special education services provided by school districts. It is important that students who receive Early Intervention Services have their eligibility for Special Education Services assessed. The State has done an admirable job in ensuring that this occurs. In 1998-1999, 170 children exited the Infant Toddler Program without being assessed for eligibility for Special Education. In 2001-2002 the total was 7 children then in 2002-2003 it was 11 children, and the most recent data show an increase to 24 children (Idaho Infant Toddler Program, 2004). Progress in originally reducing the number not assessed was attributed to an interagency grant-funded effort to address the issue. Having a performance measure for both the Infant and Toddler Program and the Special Education Program that focused on the number of children not assessed was also cited as a key factor in focusing attention on this issue. The recent rise has raised concerns and both agencies report that they will take steps to address this increase.

According to the Idaho 2002-2003 Part B performance report, about ten percent of children ages 3-21 were receiving services through Special Education in 2003-2004 (Bureau of Special Education, date unknown). The U.S. Department of Education reports that about 11.7 percent of the total enrolled student population had an Individualized Education plan at some point during 2001-2002. The U.S. Department of Education provides comparisons between States based on the December 1 count of participants which does not include students who may enter the program after that day or leave before that date. In these data, 9.7 percent of the Idaho age 6-17

population and 6.3 percent of the age 3-5 population were receiving Special Education services in December 2003. This compares with 11.5 percent of the age 6-17 population and 5.8 percent of the age 3 to 5 population for the 50 States and the District of Columbia (Office of Special Education Programs, 2004).

The number of special education students ranged from 21 in Camas County to 5,937 in Ada County.<sup>2</sup> Seven counties have over 1,000 special education students and 15 counties have at least 500. The percent of children enrolled in school with an IEP by county is shown in the map. The percentage ranges from 9.7 percent in Boundary County to 17.6 percent in Custer County. Differences between counties may be due to a variety of factors. Some of the differences may reflect differences in the population's needs, but other factors include what tools are used to identify special education children and what alternatives exist to special education services in the county. One of the concerns that the Department of Education has been addressing is that some school districts have used assessment tools that are invalid when used on immigrant students. Some of these school districts may be classifying children as special education students because they do not have programs to address the needs of students for whom English is not a native language.

---

<sup>2</sup> Idaho has 113 school districts so many counties have more than one school district.

**Figure VIII-1: Percent of School-Aged Children in IED Programs**

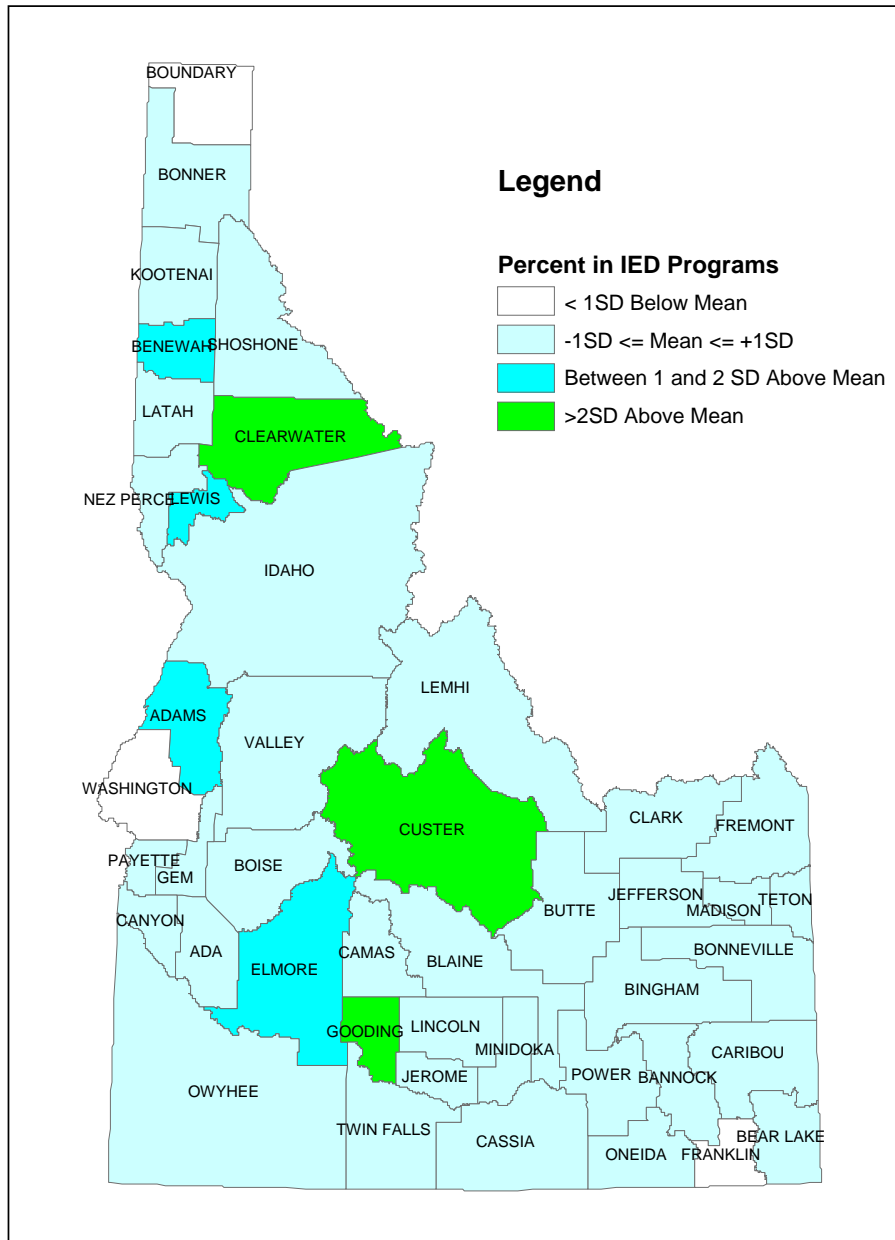


Table VIII-30 shows the reasons students are placed in the special education category. The most common reason for all children is that they are classified with a learning disability. For preschool children, learning disability is a rarely used category; instead, developmental delay is most common. Speech impairments are the second most common classification for both age groups. A key informant noted that the emotional disability classification may be underreported because schools are reluctant to use such labels with young children.

<b>Table VIII-30. Students Served By Special Education by Age Group and the 10 Most Common Disability Categories</b>			
Primary Disability	Age Group		
	Ages 3-5	Ages 6-21	All Eligible Ages
Learning Disability	0.6	50.1	43.6
Developmental Delay	58.7	6.0	12.9
Speech Impairment	24.4	9.8	11.7
Language Impairment	9.8	8.4	8.6
Cognitive Impairment	0.4	6.8	6.0
Health Impairment	1.2	6.5	5.8
Emotional Disability	0.1	4.6	4.0
Autism	1.7	2.2	2.2
Multiple Disabilities	1.0	1.8	1.7
Noncategorical Eligibility	0.4	1.2	1.1

Source: Bureau of Special Education, 2004.

Special education students receive an average of 1.7 services per child. This ranges from a low of 1.3 services per child for children classified with a speech impairment to 4.2 services per child for those classified with multiple disabilities. Table VIII-31 shows the percent of children receiving particular services by their primary disability. It should be noted that very limited family support services are provided. The percentage of students receiving family support services ranges from no deaf and deaf-blind students to 4.2 percent of emotional disabled students. The fact that these numbers are low is not surprising since school districts focus their limited resources on students. It does however speak to the need for special education programs to have connections with other service providers or family networks that can step in and provide needed services and support.

<b>Table VIII-31. Percentage of Students Receiving Specific Services By the 10 Most Common Disability Categories</b>					
<b>Primary Disability</b>	<b>Percent of Students Receiving Specified Service</b>				
	<b>Speech Service</b>	<b>Language Service</b>	<b>Occupation al Therapy</b>	<b>Physical Therapy</b>	<b>Counseling</b>
Learning Disability	17.8	30.6	7.8	1.2	3.0
Developmental Delay	21.7	29.2	13.2	5.8	0.6
Speech Impairment	70.6	9.5	2.0	0.5	0.1
Language Impairment	18.6	57.4	4.1	0.7	0.4
Cognitive Impairment	15.1	24.7	11.4	3.7	0.7
Health Impairment	13.0	18.6	16.0	7.8	4.1
Emotional Disability	4.7	5.9	2.1	0.1	17.3
Autism	12.2	26.5	15.8	3.5	0.7
Multiple Disabilities	9.6	15.3	15.4	12.2	0.3
Noncategorical Eligibility	19.1	26.1	7.0	2.3	0.9

Source: Bureau of Special Education, 2004.

The Bureau of Special Education and Medicaid have worked closely to enable school districts to become Medicaid providers and to bill Medicaid for services covered under the program. As a result, Medicaid spending on school district services has increased from \$1.9 million in FY 2001 to \$6.6 million in FY 2004. Idaho Fiscal Facts 2004 estimates that this upward trend will continue and that total charges for school district services under Medicaid will reach \$19.9 million by FY 2006. (Idaho Legislative Services Office, 2001 & 2004).

Parents in the focus groups reported vastly uneven experiences with the special education program for preschool and school-aged youngsters. While some parents were able to obtain services or have their child transferred to an alternative school setting, many more reported great difficulties in obtaining special education services. School districts offered strictly limited levels of physical and occupational therapy. Obtaining services often required a protracted battle with the school system. One of the main problems key informants cited with special education in Idaho is the extremely high caseload of special education teachers and other providers. In the 2002-2003 school year, Idaho had a ratio of 26 students per teacher providing special education. This ratio has been in the 25-26 range since the 1998-1999 school year. This compares with a ratio of 18 students per special education teacher for the nation as a whole the last year national data were available (1999-2000 school year). (Bureau of Special Education, Unknown B) The teacher shortage reflects budgetary limitations and difficulties retaining qualified teachers. The



State Department of Education conducted a survey of teachers leaving Special Education and found that the top two reasons for leaving were the amount of paperwork and the size of the caseload. It is unclear whether Idaho can address the quantity of paperwork per student issue since much of it is probably driven by Federal requirements, but the State clearly has more control over enrollment per teacher.

Rural school districts also face a real challenge obtaining the range of services needed by CSHCN and retaining teachers and staff. A few school districts have joined together to provide services. Five small school districts in southwestern Idaho have joined their Special Education programs into a single cooperative administration that has responsibility for Special Education budgets and services across districts. The State Department of Education has worked with the District to ensure that they are able to do this while complying with Federal regulations. This type of cross-district collaboration would appear to have great promise in a rural State like Idaho. There are real challenges in terms of gaining cross-district agreement and some similar arrangements have broken up over time, but it is clearly one way to enhance the level of services.

***Transition to Adult Life.*** The final Title V performance measure for CSHCN states that youth with special health care needs will receive the services necessary to make transitions to adult life, including adult health care, work, and independence. Idaho, similar to most of the rest of the country, has struggled to provide the services necessary to help CSHCN transition to adulthood. In the Idaho Families of CSHCN Survey 49 percent of parents reported needing much more information about services available to prepare for their child's transition to adulthood. Among the types of information that were asked about, the only type of information more parents needed much more information about was Katie Beckett Medicaid. Some of this may reflect that only 24.1 percent of respondents had CSHCN age 13 or over. However, National CSHCN survey data and comments from parents in the focus groups indicate that there is a great deal of room for progress on this performance measure.

As shown in Table VIII-32, the National Survey of CSHCN indicates that doctors have talked about the changing needs of CSHCN as they become adults for only half of the CSHCN over age 13. In even fewer cases is there a plan for addressing the child's changing needs. Among all CSHCN over age 13 in Idaho, 20 percent have received vocational or career training.

<b>Table VIII-32.</b> <b>Transition to Adulthood (for children ages 13 and older)</b>		
	<b>Idaho</b>	<b>United States</b>
Doctors have talked about changing needs as child becomes adult	50.2	50.0
There is a plan for addressing the child's changing needs	28.4	30.3
Child has received vocational or career training	19.6	25.5

Source: *MCHB, 2004.*

The picture is brighter in terms of transition assistance if you look at high school graduates. About three-quarters of graduates report that their high school has connected them to employment, college or community agencies such as vocational rehabilitation. However, this and other data shown in Table VIII-33 reveal why transition issues are a major concern for the special education program. There has been no increase in the number of students reporting assistance with transitions and both employment and post-secondary enrollment are lower for the Class of 2002 compared to the Class of 2000. Transition issues are a big concern for the Special Education Program. The State is taking a number of steps to improve this situation and the Idaho Interagency Coordinating Council is in the process of finalizing interagency agreements, including roles and responsibilities in transition planning.

<b>Table VIII-33.</b> <b>Indicators of Successful Transition to Adult by Year of Graduation</b>			
<b>Indicator of Successful Transition to Adulthood</b>	<b>Year of Graduation</b>		
	<b>Class of 2000</b>	<b>Class of 2001</b>	<b>Class of 2002</b>
Special Education students reporting that their high school connected them to a job, college, or community agency	75	76	74
Post Secondary Enrollment			
Special Education Students	24.5	18.4	20
All Graduates	47.8	47.6	48
Special Education students employed one year after graduation	66.2	64.6	58.5

Source: Bureau of Special Education, Unknown B.

## C. Summary Findings and Analysis

### Idaho CSHCN Outcomes

#### **CSHCN Outcome 1: Children with chronic health problems or disabling conditions use all the primary and preventive services used by typical children.**

##### **Summary**

- Less than two-thirds of CSHCN reported needing routine preventive care in the 12 months prior to being surveyed. A larger proportion of families reported needing dental care.
- Hispanic families were less likely to report that their CSHCN needed primary and preventive services than white families.
- Low income families and those who were uninsured or received publicly-funded health insurance were less likely to report needing dental care.
- Most families who reported needing preventive and primary care for their CSHCN were able to obtain care. For those who were unable to obtain care, the most common reason for not being able to do so is the cost of the care.

##### **Analysis**

- Families of CSHCN are similar to families of typical children in not always seeing the value of primary and preventive care for their children. Efforts to encourage the use of such care should include families of CSHCN.
- While families of CSHCN who say their child needs primary and preventive care are generally able to access it, decisions about what constitutes need are likely based on calculations that take into account the seriousness of condition, the cost of the care, and the ability to access services. Hispanic families and low-income families are likely deferring care because of affordability and access issues. Efforts to improve their access to primary and preventive care, especially including dental care, are important for preventing more serious health problems.
- Being unable to afford preventive care is the primary barrier to not receiving it. Low cost alternatives such as Community Health Centers and Health District immunization programs represent a key pillar in promoting use and access. It is essential that these services be supported and well publicized among all communities.

#### **CSHCN Outcome 2: CSHCN use the full range of health-related services needed to maintain their health and well-being and the services to slow, delay, or prevent untoward outcomes resulting from their chronic health conditions or disabilities.**

##### **Summary**

- Other than primary and preventive care, the most common type of care needed by CSHCN is prescription medicine, followed by care from a specialty doctor, medical supplies, and physical, occupational or speech therapy.
- CSHCN were mostly able to obtain the most commonly needed types of care.
- Mental health care or counseling was reported being needed by 15 percent of CSHCN families and was the type of care that most families (25 percent of those needing it) had difficulty accessing.
- The most common reason for not being able to access services beyond primary and preventive care was that it costs too much. However, for mental health care or counseling

## Idaho CSHCN Outcomes

and genetic counseling a lack of available providers appears to be a problem. For physical, occupational or speech therapy (26 percent of those needing care) and mental health care or counseling (17 percent of those needing care) problems with health plans were also reported by a considerable number of families.

- Problems obtaining a referral for specialty care were experienced by 18 percent of families and more than one-third of families who had a CSHCN with a serious condition and 27 percent of those enrolled in publicly funded health insurance.
- Most families report having a usual source of care for their CSHCN though it is less common among Hispanic families.
- Good communication between doctors is somewhat uncommon and good communication between doctors and other programs is even more uncommon.
- The extent to which families of CSHCN use care coordination is somewhat unclear. Evidence from the Idaho survey and focus groups indicate that the service is used and very much appreciated when it is of high quality. Privately insured families are far less likely to use care coordination or have it available.
- The changes in the CSHP Program will impose great difficulties on families who have insurance but were able to use the program to pay some of their out-of-pocket costs. CSHP families are also concerned about a quality and comprehensive service now that the clinics and care coordination responsibilities are being shifted from the local Health District offices.

### Analysis

- Access to mental health care providers and physical, occupational, and speech therapy are difficult issues for families. The State may want to examine efforts to improve access elsewhere for ideas that go beyond current initiatives (i.e., Children's Mental Health Councils). For example, Iowa has had some success using telemedicine to provide mental health services in rural areas.
- The State should reconsider whether Healthy Connections is appropriate for CSHCN with serious conditions. It is unclear that the program is meeting its cost containment goals for these families and it may be imposing an unnecessary burden on them.
- Quality care coordination is a useful service for CSHCN. The care coordination system offered through Medicaid needs to be strengthened so that at least some care coordinators are better trained in working with CSHCN families. Families of CSHCN should be able to easily tell which coordinators have experience working with such families, so some type of certification system may be needed.
- The CSHP Program could not continue as it had given the size of the budget. Efforts have been made to ensure that some of the services are continued using other resources. This change is extremely difficult for parents who participated in the program, especially those with private insurance who now face a substantial increase in out-of-pocket costs. Efforts continue to be needed to provide support for former CSHP families and for the broader CSHCN population. The existing care coordination system needs to be strengthened to ensure that communication among programs, providers, and parents is effective and that there is some way of identifying families who need assistance because they simply cannot afford the cost of needed care.

## Idaho CSHCN Outcomes

**CSHCN Outcome 3: Families of CSHCN, including their siblings, have access to and use appropriately the full range of health and health-related services required to promote their growth and well-being and manage their conditions or disabilities.**

### Summary

- 6.2 percent of CSHCN in Idaho were without insurance at the time of the National Survey of CSHCN. 12.6 percent were without insurance at some point during the year prior to the survey.
- More than one-quarter of Hispanics and non-white CSHCNs were without insurance at some point during the year prior to the National Survey of CSHCN.
- The income group at greatest risk of being without insurance is CSHCNs whose family income is just above the Federal poverty level. More than 12 percent of these families were uninsured at the time of the National CSHCN Survey and almost 24 percent were uninsured at some point during the year prior to the survey.
- Over 84 percent of families of CSHCN with insurance say that the insurance meets their needs though one-third of these families indicate that out-of-pocket costs were frequently unreasonable.
- Medicaid is considered better insurance for CSHCNs than private insurance.
- More than one-quarter of families of CSHCN experience problems because of costs associated with their child's condition. This rises to over 40 percent of families when the child's condition is rated as severe.
- Most families have positive things to say about the quality of care doctors provide to CSHCNs though about one-third of Hispanic families report that doctors often do not spend enough time with their child and often do not provide needed information.
- About one-quarter of respondents to the National Survey of CSHCN reported that community services were not usually organized in a way that made them easy to access. This opinion was both more common and stronger among focus group participants and those participating in the Survey of Idaho Families of CSHCN.

### Analysis

- Lack of health insurance is a problem for a considerable number of families with CSHCNs. The percent of Hispanic families who lack insurance at least part of the year is especially a big concern.
- Efforts should be made to ensure that families of CSHCN are not losing Medicaid because of administrative reasons. Even short periods of time without insurance can be financially devastating for families of CSHCN if it is during a period when their child needs extensive care.
- There is need for outreach directed at Hispanic families who may assume they are ineligible for Medicaid because of their citizenship status, but whose children are eligible by virtue of being born in the U.S.
- Families of CSHCN need more input into how community services are organized. The Infant Toddler Early Intervention Program's efforts in this regard may serve as a model for the broader system of services for CSHCN.

## Idaho CSHCN Outcomes

### **CSHCN Outcome 4: CSHCN use out of home childcare, preschool, and ongoing educational services as appropriate to their age, developmental stage, and health condition and/or disability.**

#### **Summary**

- It is difficult for Families of CSHCN to obtain child care.
- The Infant Toddler Program serves 2.5 percent of all Idaho children ages Birth to Three and 1.5 percent of Idaho's infants.
- Participation rates in the Infant Toddler Program vary by region. Region V has the highest participation rates while Region IV has the lowest participation rates.
- The proportion of Hispanics enrolled in the Infant Toddler Program exceeds the proportion of Hispanics in the population in Regions III, V, VI and VII. In Region I Hispanic participation rates are lower than proportion of Hispanics in the population and the two numbers are close to equal in the other regions.
- American Indians make up a larger share of participants than their share of the population in Region II. In other regions they are either underrepresented or the proportion in the Region's population is close to the proportion participating in the program.
- Data show vast differences in the percent of Infant Toddler Program participants who are involved with the State child protection agency and CSHP. Some of this may reflect differences in data collection, but it also likely reflects different levels of collaboration between programs.
- Families and friends are responsible for about one-quarter of referrals into the Infant Toddler Program, public health 20 percent, physicians 18 percent, and hospitals 17 percent.
- The State has successfully reduced the number of children exiting the Infant Toddler Program without being assessed by the preschool special education program.
- About 10 percent of Idaho's children age 3-21 receive special education services. Idaho's participation rate is lower than average for children ages 6-17 and a little higher among the preschool group.
- Special education enrollment varies tremendously by county.
- More than half of preschool special education students are classified as having a developmental delay and more than half of the age 6-21 group are classified as learning disabled.
- Speech, language, and occupational therapy are the most common services provided to students in the special education program.
- In recent years more school Special Education programs have become Medicaid providers and Medicaid spending on school related services has increased from \$1.9 million in FY 2001 to \$6.6 million in FY 2004.
- Idaho has struggled to meet requirements to help Special Education students and CSHCNs with the transition to adulthood.

## Idaho CSHCN Outcomes

### Analysis

- Medicaid, the Child Care Program and advocates for the developmentally disabled community have developed a Collaborative Task Force to study ways to promote inclusive child care in Idaho. This approach shows great promise. Medicaid has been a very forthcoming partner in helping the Special Education Program work with schools to become Medicaid providers and a similar approach with child care providers has the potential to make progress on this important issue.
- Differences across regions in participation in the Infant Toddler Program raise some important concerns. While it is hard to say what percentage of Hispanics or American Indians should be participating, more risk factors among these groups suggest the proportion should probably exceed their proportion in the population. Steps need to be taken to ensure that Districts with lower participation rates are targeting outreach efforts at these communities.
- The Infant Toddler Program has had success increasing physician referrals by targeting them for outreach and education. However, the percentage tends to decrease once targeted efforts are cut back. There is a need to explore long-term strategies for informing physicians about the program. Doctors are responsible for about 18 percent of referrals into the Infant Toddler Program.
- The Infant Toddler Program is facing a major challenge meeting its new mandate to assess all children who are determined to have been abused or neglected. This mandate provides an opportunity for Infant Toddler to work closer with CFS. However, CFS workers are faced with high caseloads and other demands so the extent to which they will actually be able to be involved in this effort is uncertain.
- The partnership between the Infant Toddler Program and the Special Education Program to reduce the percentage of children exiting Infant Toddler without being assessed is a useful model for other partnerships across the State. Part of the success reflects the importance of performance measures in Federal reporting requirements for the programs. Both programs must report trends over time on a variety of measures and account for both progress and slippage. If there is slippage a description of what will be done to address slippage is required. A similar model can help focus the work of collaborative efforts in other areas.
- The State Special Education agency is working with school districts to ensure that assessment instruments are culturally and linguistically appropriate. There is a concern that some students for whom English is not their first language are being classified as Special Education students because of misuse of these tools and because alternative services are not available. As students are reclassified it is important that services are put in place which help them succeed in school and address other needs such as health education and health care access.
- The partnership between Medicaid and Special Education has been successful in allowing more schools to appropriately use Medicaid. This enables schools to provide needed services while freeing up resources for other programs and services. Despite concerns over rising Medicaid costs it is important that Medicaid continue to work with other agencies to encourage that Medicaid be billed for services when this is appropriate. In many cases these services are already being paid for out of State dollars and are needed to prevent higher costs later on. The Medicaid Program represents an opportunity to receive substantial reimbursement from the Federal government for services needed by the people of Idaho.

### **Idaho CSHCN Outcomes**

- The Special Education Agency recognizes a need to improve transition services. This effort will need the participation of multiple agencies. Medicaid-funded care coordinators can play a role here if they are appropriately trained and have developed ties with other agencies and organizations. There is a need for training and certification procedures to ensure care coordinators are able to carry out their responsibilities for children with special needs.



## CHAPTER IX

### System Collaboration

---

Improving the health status of pregnant women, infants, children, adolescents and children with special health care needs is a complex process as many MCH problems are social problems with health outcomes. For example, the disparity in health status between ethnic, racial and tribal groups seems to be attributable to a wide array of factors and is not solely the result of the adequacy of medical care; similarly, the utilization of child and adolescent health services is influenced by a variety of family and community factors. Quality medical care, sound nutrition, adequate housing, available recreation, a nurturing family, and an array of enabling and supportive services are all essential to the health and well-being of children and adolescents.

Therefore, effectively addressing today's MCH problems and improving health status requires the active involvement of many disciplines and many public and private sector jurisdictions. Reaching a goal of promoting health and preventing problems within a State requires a broad-based systems, rather than a categorical<sup>1</sup>, approach to the issues.

The federal Health Resources and Services Administration (HRSA) defines a health care system as: the agencies, services and persons involved in providing needed care to the individual members of a community and the interactions among the agencies, services and person involved. MCHB states that an ideal system includes the following<sup>2</sup>:

- Services to help a family find and use health care effectively, learn and use self care skills to manage illness or family problems, and cope with the demands of an illness or disability. These are often called enabling or family support services
- Services to help communities and groups of people understand how they can be healthier, promote and adopt healthy behaviors, uncover community health problems and find solutions for those community problems. These are often called population-based prevention services
- Services to help communities and governments organize the health care system to assure that individual and community health needs are met, that the health status of vulnerable populations, such as children, is monitored, that services meet quality standards and that new technology is developed to address new problems. These services are often referred to as systems building and infrastructure support services.

---

<sup>1</sup> "Categorical" refers to that which involves or considers only a specific program, or jurisdiction.

<sup>2</sup> Excerpt from the *Impact of Expanding Children's Health Insurance on the Role of Maternal and Child Health Title V Programs*. Prepared for MCHB May 1998 by the Lewin Group.

---

Each component - from finding those eligible for public health insurance, to enrollment in an insurance plan, to identification of a medical home, to utilization of health services, to monitoring of the quality of health services, to assuring interactive linkages between the system components is essential to a *system* of care. A system of care enables States to support the organization, delivery, and utilization of appropriate, high quality, coordinated, and culturally competent child and adolescent health care services.

A system, as defined above, is not a group of serially arranged programs or components acting in isolation. Each of the system components must be available, accessible and responsive to the needs of all of the states' MCH population groups and families regardless of where they live, their income, or their racial, ethnic, or tribal heritage. In addition, each of these components must be able to communicate to assure coordination and avoid fragmentation and duplication.

System collaboration is an attempt to orchestrate services across agencies, organizations, and disciplines with the goal of improving the organization and delivery of care to obtain positive health outcomes for the families and children who use the system. Because maternal and child health is the responsibility of so many agencies, organizations and individuals it very much requires a systems approach if a State's goals in this area are to be successful.

***Idaho MCH System-building Efforts.*** There are a wide variety of system collaboration efforts occurring in Idaho. Many of them have achieved some success in improving services and outcomes. This section examines a small number of these initiatives at the State and local level by MCH population groups. The purpose of this section is not to document every effort but to describe a representative selection of the existing system collaboration efforts and describe ways in which these efforts might be strengthened.

## **A. Pregnant Women and Infants**

***The Idaho Perinatal Project.*** The Idaho Perinatal Project (IPP) was initiated in the late 1970's. Babies are delivered in about three dozen hospitals across the State and the need was identified for improved coordination of key services. The project originated over concerns regarding the transport and transfer of patients between hospitals. Over the past few decades the group has addressed a variety of issues including care for children with PKU, newborn hearing screening, nursing capacity issues, the role of nurse midwives, assessing pain in newborns, hospital construction, epidural rates, and delivery induction rates.

The IPP currently has four goals:

- Initiate and support the creation of a database for maternal/child outcomes. Correlate, analyze, and make recommendations regarding maternal/child statistical data for the state of Idaho.
- Provide education to perinatal health care professionals, and the general public.

- Become recognized as a main resource and advocate in maternal/infant health by:
  - Institutions and providers of maternal/infant health care;
  - Legislators and the governor;
  - Other maternal/infant health organizations; and
  - The general public.
- Assess board membership annually to assure appropriate representation.

While the IPP was previously funded with State money, financial support is now provided by St. Luke's hospital. The vast majority of the independent advisory board consists of practitioners or individuals involved in medical education. An employee of the Bureau of Vital Statistics is the sole representative from the Idaho Department of Health and Welfare. The Executive Director of the Idaho March of Dimes and a representative from the local District Health Department that covers Boise are also on the Board.

The Idaho Perinatal Project is to be commended for its successes and longevity. Far too many collaborative efforts tend to peter out in a short time. The group has raised many key issues involving pregnancy and childbirth and its role in promoting the conference has created a venue that brings together a range of providers across different disciplines. These are not easy tasks and many organizations around the country struggle with them. The limitations of the IPP are that: it is seen by some around the State as focused too heavily on issues involving the Boise metropolitan area; there are some who feel it is too closely linked to St. Luke's to provide a comprehensive focus; and there is no State agency representative who can present or address the needs of the whole maternal and child health population when it comes to perinatal issues. The latter issue exists because no one at the State-level currently is charged with this responsibility.

***Pregnancy Wellness Coalition.*** The Pregnancy Wellness Coalition is a community-based collaborative serving North-Central Idaho. The director of the coalition is the grant-writer for Clearwater Valley Hospital and Clinics based in Orofino and St. Mary's Hospital and Clinics based in Cottonwood. The coalition brings together physicians and other health care providers and non-traditional professionals such as lay midwives. The group seeks to promote a common message of the importance of prenatal care and breastfeeding. The role of the coalition is to problem-solve and share information and resources.

The Coalition has taken on a number of projects including the creation of prenatal and breastfeeding information bags that are provided to families. Lay midwives are also encouraged to use these information bags. The hospital has a Parents as Teachers Program which has enabled them to reach women who deliver using lay midwives. The Parents as Teachers staff have used these contacts to build relationships with the midwives and obtain their participation in the coalition. Building relationships with lay midwives has been challenging because there is a great deal of mistrust between physicians and the midwives. There are also concerns among doctors about liability issues if they work too closely with the midwives and something goes wrong. The group has succeeded in opening dialogue, improving communication and creating information sharing mechanisms.

However there are limits to the reach of the collaboration as the local health district has not been very involved. One of the physicians involved in the coalition reported struggling to get the local health district to utilize local hospital resources rather than referring to distant providers. She has been able to obtain some response, but the efforts have been somewhat one-sided with District staff still not routinely making efforts to learn about the potential for the hospital to be a resource for its clients.

## **B. Children and Adolescents**

***Early Care and Learning Task Force.*** The Task Force was created by the Governor's Coordinating Council for Families and Children in February 2004. This group was given the responsibility for developing a sustainable and coordinated statewide-plan to achieve mutually defined goals for early care and learning. It is the planning body for the State Early Childhood Comprehensive Systems (SECCS) Grant that the Maternal and Child Health Bureau has provided to Idaho and 47 other States. Early care and learning is broadly defined to include health, mental health, family support, and parenting education as well as child care and early education services from the prenatal period through age 5. The purpose of the task force is to develop multi-agency partnerships among key stakeholders, and then develop and implement a plan for an early childhood system. The Task Force is in the process of completing its plan and will be applying for implementation funding from the Federal government. The strength of the group is that it represents a comprehensive approach to early childhood and has the support of the Governor's office. Among the challenges is ensuring representation from across the State of Idaho and ensuring its work will be sustained when the Governor's office eventually changes hands.

***The Idaho Governor's Council on Adolescent Pregnancy Prevention (IGCAPP).*** The Council's mission is to reduce adolescent pregnancy in Idaho by increasing the number of teens choosing abstinence. The Council was created by Executive Order in 1990s and its duties include: development and implementation of a statewide campaign focused on delaying sexual activity by adolescents; and the assessment and reporting of the impact of the campaign on reducing the rate of adolescent pregnancy.

IGCAPP encourages communities to investigate and implement the most promising teen pregnancy prevention programs and supports the development of statewide strategies that foster positive relationships with community partners in youth development and adolescent pregnancy prevention efforts. At the local level the Council seeks to bring together child advocates, community organizations including faith-based institutions, business, public schools, teens and parents to discuss the needs of teenagers and develop strategies for delaying sexual activity and preventing pregnancy. One of the Council's current initiatives is a partnership with the Association of Idaho Cities to provide small grants to projects where groups of young people take a leadership role in identifying and addressing teen pregnancy prevention efforts through community supported asset-based approaches.

***Success By Six.*** A number of the United Ways in Idaho have developed Success by Six Initiatives. Among those which have been particularly active are United Way of Southeastern Idaho and United Way of Treasure Valley. Success by Six is a partnership of business,

government, education, parents, organizations, civic groups and agencies that is designed to maximize resources. The Success by Six initiative organized by the United Way of Southeastern Idaho conducted a community needs assessment and determined that there was a need for a focus on improving child care; early literacy and learning opportunities; the availability of family activities and family's knowledge of resources; and assuring health and safety for young children. In Treasure Valley, Success By Six has developed a parent guide, become the Parent as Teachers State Affiliate for the area, developed a parents resource center, and convened a forum for a federally-supported early childhood collaborative effort. Even though the latter effort has ended, Success By Six has continued to support collaboration among early childhood community partners in the area. This is important because collaborative efforts are often the product of short-term funding and it is sometimes difficult to maintain them once the funding ended.

## C. Children With Special Needs

***Infant and Toddler Interagency Coordinating Council and Regional Infant and Toddler Committees.*** The ICC is a Federally-mandated interagency group that provides guidance for the Infant-Toddler Program. The council's responsibilities are to:

- Review emerging issues, gather information and make policy recommendations.
- Advocate for services and funding which will positively impact children and families.
- Educate the community about the importance and availability of early intervention services.

The ICC includes representatives from the CSHP, Child Care, and Developmental Disabilities Programs in the Department of Health and Welfare, the Department of Education, parents, providers, the legislature, the Idaho Migrant Council, Head Start, a District Health Office, and the insurance industry. Seven Regional Infant Toddler Committees were established to ensure responsiveness to the local needs of Idaho families. A representative of each regional committee attends ICC meetings, presents issues and provides input about early intervention services throughout the state.

Key informants had very positive comments on the Infant and Toddler Programs coordination efforts. Parent advocacy groups praised the program's openness to parental input. The program itself generally gets positive reviews and this may partially reflect its openness to collaboration.

***Children's Mental Health Councils.*** As described in the chapter on Health Infrastructure, Idaho is in the process of developing a system of care for children with mental health problems. The system involves councils at the Statewide, regional, and local level. Different agencies and programs are brought together for planning purposes and, at the local level, to develop services plans for individual children. While still in its initial stages the initiative represents an innovative effort that bears watching by the whole health and social service community in Idaho. As

implementation proceeds, other programs and initiatives across the State will have an opportunity to learn from the experience of these councils.

## **D. Cross-Population Initiatives**

***The Governor's Coordinating Council for Families and Children.*** Governor Dirk Kempthorne created the Governor's Coordinating Council for Families and Children (GCCFC), made up of representatives of government agencies, civic groups, non-profit organizations, businesses and the faith community. Led by Co-chairs First Lady Patricia Kempthorne and Dr. Jerry Hirschfeld, administrator of St. Luke's Children's Hospital, the Governor's Coordinating Council began its work in 2000 to inventory, coordinate and increase the resources available to families and children in Idaho. Every two years the Council has sponsored Governor's Roundtables in different regions across the State to highlight collaborative efforts and share ideas across programs and initiatives. The Coordinating Council has developed a Community Collaboration Contracts program that provides small amounts of funding for collaborative programs focused on improving child outcomes. The Council has created Task Forces on early care and learning (as described above), substance abuse among pregnant women, and mental health.

***Service Integration in the Department of Health and Welfare.*** Integrating health and human services is goal number three of the Idaho Department of Health and Welfare Strategic Plan. This goal is essential to the meeting the needs of the maternal and child health population in Idaho. As a strategy to operationalize this goal, the primary job of Directors of Regional Health and Welfare offices has become fostering community collaboration. The Moscow office of Region 2 has served as a pilot site for the Any Door initiative which is designed to reorganize how services are delivered in a way that fosters service integration within the Department and with other community resources.

The Any Door model that was tested in Moscow and is now being used in other areas of Region 2 included the creation of a navigation specialist position within the Regional Health and Welfare office. When someone comes into the Regional Health and Welfare office to apply for or inquire about benefits they are asked to meet with a navigation specialist. The goal of the specialist is to determine if there are alternative services, additional services, or other needs that can be addressed in an individual case. For example, if someone is applying for food stamps because they are having difficulty finding a job, the navigation specialist will help them locate services that will address the reasons they have been unable to find a job. The goal is to try and identify the issues behind the assistance request in order to help the person achieve their full potential. The belief is that by doing so fewer people will remain on financial assistance for long periods of time. At this point the effectiveness of the effort is documented primarily by anecdotes of particular cases. These are instances where the Navigation Specialist was able to obtain assistance to address an underlying problem when in the past no one would have uncovered the problem. Other data collected include the number of people served through Any Door.

With the exception of Region 2 the Systems Integration Initiative is just getting underway. While it is too early to determine the impact of the Initiative, there are some initial indications of what is working well and what needs more attention. The strengths of this initiative are that it brings together a wide variety of services, is focused on the family not just individual members, and

includes Medicaid staff. Challenges include the heavy focus on collaboration for services provided through Regional Health and Welfare offices.

The involvement of the District Health offices, which represent one of the most obvious partners for this effort, has thus far been very limited. This disconnect between the District Health Offices and The Regional Health and Welfare Offices is a reoccurring issue that represents an impediment to effective collaboration between health and human services in Idaho. Reasons for this disconnect vary and include: concern over limited staff time and other resources; concern that working with welfare will result in a “welfare” label being applied to health district services; poor interpersonal dynamics between directors of the various agencies; concern over maintenance of autonomy; and lack of an emphasis on collaboration at the State level. While these are challenges to overcome there is no reason to believe they are insurmountable. A strong effort to encourage and reward collaboration between these agencies would be a major step in systems-building in Idaho. While the Health Districts are one of the major partners for a systems integration effort other partners should also be brought to the table. These include Community Health Centers, local hospitals, and Medicaid care coordinators.

***North Idaho Rural Health Consortium (NIRHC)*** A community level example of a cross-population systems collaboration initiative is North Idaho Community Connections. This effort brings together hospitals, Community Health Centers, the District Health Department, and a provider network to improve services across a wide area of Northern Idaho.

Hospital organizations participating in NIRHC include:

- Benewah Community Hospital
- Bonner General Hospital
- Boundary Community Hospital
- Kootenai Medical Center
- Shoshone Medical Center

Community Health centers participating include:

- Dirne Community Health Center
- Boundary Regional Community Health Center
- Benewah Medical Center

Also participating are three community volunteer clinics that are overseen by the Panhandle District Health office and the North Idaho Health Network.

Using a variety of federal grant funds, NIRHC seeks to improve the information infrastructure and develop a wide area IP network to increase access to a coordinated information system for providers. In 2002-2003, the NIRHC received funds to upgrade the existing infrastructure to

support the implementation of telehealth services including mental health services; school based rehabilitative therapies for special needs children, telepharmacy, telepathology, and tele-ER services. The NIRHC and the Health District also provide mobile health and dental services to the underserved rural areas within the region.

## **E. Opportunities for Enhancing System Collaboration**

This section has documented some of the efforts to engage in system collaboration and systems development in Idaho. There is no shortage of efforts and a number of them are producing results. The rest of this chapter examines steps that could be taken to strengthen the systems development efforts.

***Putting the Pieces Together.*** This section of the report has documented a large number of systems collaboration efforts. There are, no doubt, additional activities that have not been listed here. Efforts have been created in response to problems such as the Jeff D. lawsuit concerning services to mentally ill children, as a result of Federal mandates or grant opportunities and because Idahoans saw a problem and felt that better collaboration across programs would improve services. The end result is a wide range of efforts that sometimes have overlapping responsibilities, but do not appear to have clearly defined roles in developing policies or recommendations. In order to enhance these efforts and further their goals a few issues have to be addressed.

- There is a need to consider how all these efforts fit together and how they can best be organized so that systems improvement is more likely to occur and be sustained over time. The problem with having so many collaborative efforts is that the energy they produce can become dissipated and people's time may become completely consumed by meeting to discuss issues rather than implementing positive changes.
- There is a need to ensure that efforts initiated by a particular Department, such as Health and Welfare's Systems Integration Effort, fully include other obvious partners such as District Health Department's. There is a need to make sure organizations that are growing in importance, such as the State's Community Health Center's find a seat at the table as active participants in system development efforts both at the State and local level.
- Opportunities for family involvement and family input need to be enhanced. Families provide a crucial perspective on issues and can help agencies understand how their policies are perceived by the people they serve. Their presence in planning is both beneficial to the planning and the right thing to do since they are the people most affected by the plans that are made.
- Finally, there is a need for State and local agencies to send a consistent message through contract language, policies, practices, regulations, and performance measures that collaboration among providers and with consumers is the expected way of providing health and social services in Idaho.



***Regional Models of Collaboration.*** A regional model of collaboration is a promising idea for a variety of issues in Idaho. Collaborative efforts that focus on CSHCN across the life span and include the Infant Toddler Program, School District Special Education staff, BOCAPS staff, physicians and hospitals and Medicaid care coordination providers could help to create a better coordinated system of services for CSHCN. A regional effort would also provide an excellent setting for addressing parent's concerns that they lack information about what is available for families of CSHCN. BOCAPs could contribute Title V resources to help develop these regional entities and to provide support for their initiatives. This would allow BOCAPs to better fulfill its Title V mandate to ensure the health of all children, including CSHCN.

Regional Perinatal Councils, including a wide range of providers, could address issues around pregnancy and child birth. These Councils could help enhance the work of the Idaho Perinatal Project and address concerns that IPP has spent limited time addressing the needs of the State beyond the Boise area. IPP in collaboration with the Regional Councils would be in position to create a screening process for high-risk women that could be recommended for physicians, health centers, and lay midwives. Protocols could be developed for handling cases at various risk-levels. While it may be impossible to mandate that particular screening tools be used, if a visible, well connected, planning body creates and promotes a practical tool for screening pregnant women there is likely to be a strong interest in adopting it. In some areas regional collaboration efforts could serve as a spur to creating county-level collaboration councils that could work on county issues and convey those concerns to the regional collaboration bodies. Participants in a number of focus groups conducted by Regional Health and Welfare Directors as part of the development of a performance improvement plan for child protective services expressed an interest in creating collaborative efforts at the county level encompassing a broad range of services.<sup>3</sup>

The Early Learning Issues Group Report to the Governor's Coordinating Council recommends the establishment of Cross System Coordinating Committees by Region. The purpose of the Councils would be to "stimulate local awareness, collaboration and funding momentum." They suggest that Success by Six is a potential organization that could accomplish this.<sup>4</sup> While there are advantages of placing responsibility for organizing this outside the government, it is also important that State and local agencies be strongly encouraged to be active participants in such an entity. The expectation of participation in collaboration should be written into contracts, job descriptions, memorandums of understandings and similar documents in order to create a culture that fosters cooperation and collaboration. Agencies should combine resources to offer incentives such as small flexible grants and technical assistance to support collaborative efforts.

***Focusing on Outcomes.*** System collaboration efforts need to define the results and outcomes they want to pursue. While these may change over time, developing a set of such outcomes and results is needed to keep the efforts focused. Good results help produce momentum and attract further support. These types of measures also allow for a reevaluation of approaches when the data do not show progress. While there are a variety of types of data including qualitative assessments it is important to be able to produce solid data that can document progress. This includes numbers on the well-being of children and families, but also numbers that reflect

---

<sup>3</sup> *Performance Improvement Project Focus Groups Executive Summary.* Idaho Department of Health and Welfare. 2004.

<sup>4</sup> *Early Learning Issues Group Report to the Governor's Coordinating Council.*

---

whether a program is performing well. In some cases these data are being collected, but not being used. In others they have never been collected. As part of the focus on outcomes it is important that agencies and organizations examine how they use data. In interviews with District Health and Regional Health and Welfare staff we found that they do not feel they have the types of data available which can be used to guide program decisions. Remediating this problem can help create a tool which fuels the collaborative approach.

The collaborative approach has led to many achievements across Idaho. MCH stakeholders can build on these accomplishments to ensure that the families of the State have access to the services and supports needed to promote the health and wellness of Idaho's children.

## CHAPTER X

# Opportunities for Strengthening Maternal Child Health in Idaho

---

Described throughout the assessment report are a number of initiatives, programs and services that are in place and serve Idaho's MCH populations. This section of the assessment report focuses on opportunities available to strengthen MCH outcomes in Idaho by building on existing and mobilizing new efforts.

### **A. Promoting a systems-approach to the planning, organization, delivery and evaluation of MCH services.**

#### **1. *Putting the System Pieces Together***

Several system-building efforts have been described in this report and the focus on a system rather than a categorical approach to service delivery has occurred for a number of reasons. These include a response to the Jeff D. lawsuit concerning services to mentally ill children, the result of Federal mandates or grant opportunities, or because Idahoans saw a problem and felt that better collaboration across programs would address it.

However these activities have resulted in a wide range of collaborative efforts with overlapping goals that are without clearly defined roles in developing policies or recommendations. At the state policy level a number of issues must be addressed to create a climate and an infrastructure in which the system pieces can be put together. The following are specific opportunities that may be considered in addressing system-building issues.

#### **2. *Develop a Results-focused Systems-building Framework***

Important to consider is how all the individual system and collaboration efforts can be organized to fit together to obtain synergy and bring about change. System collaboration efforts need to define the results and outcomes they want to pursue. Another important issue is how to sustain these efforts over time. A negative result of many collaborative efforts is the consumption of resources (time and money) that occurs from the repetitive discussion of the same issues in various collaboration venues leaving little time and energy for the actual implementation of change.

Organizing system efforts by the general results and the more specific outcomes that policy-makers want to achieve can be an effective way to bring the pieces together. Agreement on a set of such outcomes and results that transcend individual agencies or disciplines will go a long way toward keeping the collaboration efforts focused and helping to maintain momentum and thereby attract further support. An outcome/results focus permits the use of specific monitoring measures to assess in real time the effectiveness of particular initiatives or activities. A results-focus also helps to guide the collection of appropriate data that will lead to the development of information needed to determine progress.

**a. Ensure That All the System Partners are at the Collaboration Table**

Since MCH health and wellness status is impacted by an array of factors and is addressed by so many groups and agencies, it is essential that all the partners are brought together and that all have meaningful roles in the collaboration process. For example, initiatives that are started by a particular Department, such as Health and Welfare's Systems Integration Effort, should fully include other obvious partners such as District Health Departments. In addition, there is a need to make sure organizations that are growing in importance, such as the State's Community Health Center's find a seat at the table as active participants in system development efforts both at the State and local level. Finally, the involvement of families can be crucial to the collaborative process ensuring that the system planned is the system families' need. This involvement is also a way to promote family-state agency relationships that are positive and collegial rather than negative and adversarial.

**b. Promote the System Message**

It is essential that all the MCH stakeholders speak with one voice about system-building and collaboration so that this message becomes part of the culture of planning and implementing services in Idaho. This can be accomplished through joint policy development, common regulations, shared procedures, contract language, and performance measures. Everyone needs to understand that collaboration among providers and with consumers is how "Idaho does business".

**3. *Getting The System to Deliver Services That Meet the Needs of Consumers, Providers and Policy-Makers***

**a. Facilitate Cross-system Training**

For a number of reasons including funding structures, all too often the response to a perceived problem is to start another "program". Over time this results in the establishment of multiple categorical silo efforts that consume resources, confuse consumers, and frustrate providers. Very often MCH population groups are served by and are know to an array of the same providers. If these providers, all of whom are serving the same groups, were cross-trained to provide information, referral and guidance about a number of services or needs, it would be possible to do a lot more service with a lot less resources. For example, Medicaid staff would have basic information about prenatal care, child health (including immunizations), and family planning resources. Public health staff would have basic information about Medicaid and SCHIP

eligibility and enrollment. The assessment has clearly documented the need for dissemination of *accurate* information to both providers and consumers about services needed by families. The conduct of regular, ongoing cross-program, cross-agency training could go a long way toward addressing this need.

## **b. Turning Data into Information**

In interviews conducted with District Health and Regional Health and Welfare staff, the lack of available data that can be turned into information and then used to guide program decisions was identified as a major issue. This was also identified as a high priority by the CAST-5 workgroup. Data that was collected was not always the data needed to assess outcomes and measure performance. At other times, data collected was not analyzed and/or displayed in a fashion so that it could be readily used by decision-makers to make program changes.

## **B. Operationalizing a systems-approach to the planning, implementation and delivery of services.**

### **1. *Promote Regional Models of Collaboration***

Due to the geographic distances in Idaho and its culture of individualism, regionalization may be a promising approach to collaboration and system-building. In fact several of the collaboration efforts described earlier are focused on specific geographic areas of the state. The use of a regional approach puts boundaries around the collaboration issues thereby making resolution of the issues more manageable. The region can examine the continuity of care issues within the context of available resources and determine how to link those resources and use them most efficiently and effectively. For example, a perinatal regional approach to care would focus on the availability of and access to prenatal care, the identification of high-risk women, development of care coordination and referral/transfer protocols for high-risk women, links to community support and enabling services, and arrangements for delivery at an appropriate facility. Also important are linkages for post partum care to include screening for depression and ongoing primary care. Regional entities could enhance the work of the Idaho Perinatal Project and address concerns that IPP has been unable to adequately address beyond the Boise area.

Another example is a regionalized approach to CSHCN services across the life span. Stakeholders would include the Infant Toddler Program, School District Special Education staff, BOCAPS staff, physicians and hospitals and Medicaid care coordination providers could help to create a more responsive and coordinated system of services for CSHCN. A regional effort would also provide an effective mechanism for addressing parent's concerns that they lack information about what is available for families of CSHCN and have limited input into CSHCN planning.

BOCAPs could contribute Title V resources to help develop these regional approaches and provide overall support for the initiatives. This would allow BOCAPs to better fulfill its Title V mandate to ensure the health of *all* children, including CSHCN. In some areas regional collaboration efforts could serve as a spur to creating county-level collaboration councils that

could work on county issues and convey those concerns to the regional collaboration bodies. Participants in a number of focus groups conducted by Regional Health and Welfare Directors as part of the development of a performance improvement plan for child protective services expressed an interest in creating collaborative efforts at the county level encompassing a broad range of services.<sup>1</sup>

The Early Learning Issues Group Report to the Governor's Coordinating Council recommends the establishment of Cross System Coordinating Committees by Region. The purpose of the Councils would be to "stimulate local awareness, collaboration and funding momentum." They suggest that Success by Six is a potential organization that could accomplish this.<sup>2</sup> While there are advantages of placing responsibility for organizing this outside the government, it is also important that State and local agencies be strongly encouraged to be active participants in such an entity. The expectation of participation in collaboration should be written into contracts, job descriptions, and memoranda of understanding and similar documents in order to create a culture that fosters cooperation and collaboration. Agencies should combine resources to offer incentives such as small flexible grants and technical assistance to support collaborative efforts.

## **2. *Coordinate the Regional Collaboratives***

While it is important in Idaho that local needs and customs drive service delivery, it is also important to link state and regional efforts to assure cross-regional consistency and accountability. It is difficult to assure that all entities at the regional and local levels not only have access to current state policy directives but also that they *understand* the policy directives and are able to accurately describe and apply them. During the course of the assessment, many key stakeholders and consumers shared their understanding of particular rules and regulations which not always accurately reflected state policies and procedures. These misunderstandings and misconceptions can create a myriad of problems ranging from preventing eligible individuals from obtaining services they need to significantly damaging relationships between consumers and providers and among provider groups.

A collaborative systems-focused approach has led to many achievements across Idaho. MCH stakeholders can build on these accomplishments to ensure that the families of the State have access to the services and supports needed to promote the health and wellness of Idaho's children.

---

<sup>1</sup> *Performance Improvement Project Focus Groups Executive Summary*. Idaho Department of Health and Welfare. 2004.

<sup>2</sup> *Early Learning Issues Group Report to the Governor's Coordinating Council*.

## *Appendix A: Key Informants*

---

# **Idaho Title V Needs Assessment Key Informant Interview Protocol**

## **I. Introduction**

We are from Health Systems Research, a policy analysis and consulting firm, and we are helping the Idaho Department of Health and Welfare conduct a 5-Year Needs Assessment that is required as a condition of receiving the Federal Maternal and Child Health Block Grant. The purpose of the needs assessment is to identify needs and assess current services directed at pregnant women, mothers, infants, children, adolescents, and Children with Special Health Care Needs and their families as well as the capacity of the system to address these needs. This interview will take about an hour. Do you have any questions before we begin?

1. What is your title and how long have you been in this position?
2. Briefly describe your responsibilities.

## **II. MCH Targeted Groups**

I would like to go through each of the population groups covered by this needs assessment and ask some questions about your agencies experience providing services for them. Please consider the overall picture and variations in services and system capacity by race/ethnicity, SES, geographic areas and income.

### **A. Pregnant Women**

1. What services and initiatives does your agency provide or support that address the needs of pregnant women? (Determine and indicate if these are direct, enabling, population-based or infrastructure services and initiatives)
2. What do you see as your agencies' major strengths in this area?
3. What do you see as the biggest challenges... for your agency? For the (state/region) as a whole? (explore both service challenges and capacity challenges)
4. Are there any unmet needs for this population that we have not discussed yet?
5. Could you provide me with some examples of the outcome indicators used by your agency to measure the performance of your agency in meeting the needs of pregnant women?



**B. Mothers**

1. What services and initiatives does your agency provide or support that address the needs of mothers?
2. What do you see as your agencies' major strengths in this area?
3. What do you see as the biggest challenges....for your agency? For the (state/region) as a whole? (explore both service challenges and capacity challenges)
4. Are there any unmet needs for this population that we have not discussed yet?
5. Could you provide me with some examples of the outcome indicators used by your agency to measure the performance of your agency in meeting the needs of mothers?

**C. Infants**

1. What services and initiatives does your agency provide or support that address the needs of infants?
2. What do you see as your agencies' major strengths in this area?
3. What do you see as the biggest challenges....for your agency? For the (state/region) as a whole? (explore both service challenges and capacity challenges)
4. Are there any unmet needs for this population that we have not discussed yet?
5. Could you provide me with some examples of the outcome indicators used by your agency to measure the performance of your agency in meeting the needs of infants?

**D. Children**

1. What services and initiatives does your agency provide or support that address the needs of children?
2. What do you see as your agencies' major strengths in this area?
3. What do you see as the biggest challenges....for your agency? For the (state/region) as a whole? (explore both service challenges and capacity challenges)
4. Are there any unmet needs for this population that we have not discussed yet?

5. Could you provide me with some examples of the outcome indicators used by your agency to measure the performance of your agency in meeting the needs of children?

**E. Youth/Adolescents**

1. What services and initiatives does your agency provide or support that address the needs of adolescents?
2. What do you see as your agencies' major strengths in this area?
3. What do you see as the biggest challenges....for your agency? For the (state/region) as a whole? (explore both service challenges and capacity challenges)
4. Are there any unmet needs for this population that we have not discussed yet?
5. Could you provide me with some examples of the outcome indicators used by your agency to measure the performance of your agency in meeting the needs of adolescents?

**F. Children with Special Health Care Needs and Their Families** (CSHCN are children or youth with a chronic health condition or disabling condition)

1. What services and initiatives does your agency provider or support that address the needs of children with special health care needs and their families?
2. What do you see as your agencies' major strengths in this area?
3. What do you see as the biggest challenges....for your agency? For the (state/region) as a whole? (explore both service challenges and capacity challenges)
4. Are there any unmet needs for this population that we have not discussed yet?
5. Could you provide me with some examples of the outcome indicators used by your agency to measure the performance of your agency in meeting the needs of children with special health care needs?

**G. Collaboration**

1. Overall how well do the different agencies and organizations collaborate in serving the maternal and child health population? At the State level? At the regional and/county level?
2. Are there particular areas or populations where collaboration is especially strong? Are there particular areas or populations where collaboration is weaker?

3. In what ways could collaboration be improved? (Explore the barriers to collaboration)

#### **H. Biggest Issue Facing MCH Population**

Considering all we have discussed what do you see as the biggest issue in regard to the MCH population in Idaho? Why do you think this is the biggest issue?

### **III. Reports and Data**

As part of this needs assessment we are attempting to compile reports and data that address issues relevant for the MCH population.

1. Are there any reports, data, or a needs assessment, that you would be able to provide?
2. Are there any reports or data produced by other agencies or organizations that you would recommend?

### **IV. Closing**

Thank you very much for your time. If you think of anything else you would like to add feel free to get in touch with me.

***Appendix B: Key Results from the Family Health Survey  
and CSHCN Survey***

---

**Family Health Survey**  
**Questions 14, 17, 23, 24, 27**

Question 14: When living in Idaho, when you or your partner were pregnant did you ever need help with...												
Service			Yes, needed help.....									
			No, did not need help		But didn't seek help		Looked, but couldn't find		Found people and/or information but never used it		Found people and/or information to assist, but it was not helpful	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Finding prenatal care	269	57.6%	3	0.6%	5	1.1%	0	0%	8	1.7%	182	39.0%
Paying for prenatal care	162	34.9%	24	5.2%	9	1.9%	3	0.7%	20	4.3%	246	53.0%
What to expect regarding pregnancy and child birth	194	42.0%	5	1.1%	2	0.4%	3	0.7%	19	4.1%	239	51.7%
Advice on healthy eating	190	41.0%	13	2.8%	5	1.1%	8	1.7%	15	3.2%	233	50.2%
Information on what to do once the baby arrives	194	42.2%	8	1.7%	7	1.5%	4	0.9%	20	4.4%	227	49.4%
Worries about whether the baby would be born healthy	214	46.7%	6	1.3%	5	1.1%	3	0.7%	12	2.6%	218	47.6%
Alcohol or drug use	414	90.2%	4	0.9%			2	0.4%	3	0.7%	36	47.6%
Quitting smoking	385	84.4%	13	2.9%	3	0.7%	8	1.8%	11	2.4%	36	7.9%
Feeling depressed or nervous	294	64.2%	44	9.6%	13	2.8%	8	1.8%	15	3.3%	84	18.3%

Question 17: While living in Idaho, When you had an infant (birth to one year old) did you or your partner ever need help with . . .												
Service	No, did not need help		Yes, needed help.....									
			But didn't seek help		Looked, but couldn't find		Found people and/or information but never used it		Found people and/or information to assist, but it was not helpful		Found people and/or information to assist and it was helpful	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Finding a doctor for your infant	267	57.4%	3	0.7%	4	0.9%	3	0.7%	10	2.2%	178	38.3%
Paying for a doctor for your infant	192	41.2%	16	3.4%	10	2.2%	2	0.4%	16	3.4%	230	49.4%
Finding someone to take care of your baby while you worked or went to school	249	53.6%	13	2.8%	37	8.0%	4	0.9%	33	7.1%	129	27.7%
Breastfeeding	233	50.4%	8	1.7%	6	1.3%	8	1.7%	32	6.9%	175	37.9%
Feeling sad, blue, or depressed	261	56.9%	47	10.2 %	17	3.7%	7	1.5%	17	3.7%	110	24.0%
Feeling overwhelmed	241	52.4%	58	12.6 %	20	4.4%	6	1.3%	60	4.4%	115	25.0%
Concerns that your baby was not growing or developing like he or she was supposed to	312	67.4%	3	0.7%	6	1.3%	2	0.4%	6	1.3%	134	28.9%

Question 20: While living in Idaho, when you had a young child (ages 1 to 12 years old) did you ever need help with. . .												
Service	No, did not need help		Yes, needed help.....									
			But didn't seek help		Looked, but couldn't find		Found people and/or information but never used it		Found people and/or information to assist, but it was not helpful		Found people and/or information to assist and it was helpful	
	n	%	n	%	n	%	n	%	n	%	n	%
Finding a doctor for your child	302	59.9%	8	1.6%	8	1.6%	2	0.4%	13	2.6%	171	33.9%
Finding a dentist for your child	255	51.3%	21	4.2%	31	6.2%	6	1.2%	26	5.2%	158	31.8%
Finding someone to take care of your baby while you worked or went to school	272	54.5%	19	3.8%	38	7.6%	8	1.6%	32	6.4%	130	26.1%
Advice on making sure your child was eating right	275	55.2%	5	1.0%	5	1.0%	6	1.2%	11	2.2%	196	39.4%
Concerns that your child felt sad, blue, or depressed more than he or she should	383	76.8%	13	2.6%	9	1.8%	5	1.0%	13	2.6%	76	15.2%
Using appropriate discipline with your child	323	64.9%	18	3.6%	15	3.0%	7	1.4%	5	1.0%	130	15.2%
Concerns that your child was not growing or developing like he or she was supposed to	349	69.5%	6	1.2%	5	1.0%	3	0.6%	8	1.6%	128	25.7%
Concerns that you child could not sit still, focus on directions, or concentrate as well as other children his or her age	360	72.1%	14	2.8%	13	2.6%	3	60.0%	13	2.6%	96	19.2%
Concerns that your child was overweight	432	72.1%	9	1.8%	5	1.0%	3	0.6%	14	2.8%	35	7.0%

Question 23: While you were living in Idaho when you had a teenager (ages 13 to 19 years old) did you ever need help with . . .												
Service			Yes, needed help.....									
			No, did not need help		But didn't seek help		Looked, but couldn't find		Found people and/or information but never used it	Found people and/or information to assist, but it was not helpful	Found people and/or information to assist and it was helpful	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Finding a doctor for your teenager	109	65.7%	3	1.8%	3	1.8%	3	1.8%	7	4.2%	41	24.7%
Paying for a doctor for your teenager	82	50.3%	18	11.0%	6	3.7%	2	1.2%	10	6.1%	45	27.6%
Finding a dentist for your teenager	94	58.0%	4	2.5%	13	8.0%	1	0.6%	12	7.4%	38	23.5%
Concerns that your teenager was overweight	121	73.8%	15	9.2%	3	1.8%	3	1.8%	3	1.8%	19	11.6%
Using appropriate discipline with your teenager	109	65.7%	12	7.2%	6	3.6%	1	0.6%	10	6.0%	28	16.9%
Concerns that your teenager felt sad, blue or depressed more than he or she should	98	59.4%	7	4.2%	6	3.6%	3	1.8%	14	8.5%	37	22.4%
Concerns that your teenager was lonely, socially immature or having trouble making friends	113	68.5%	11	6.7%	11	6.7%	2	1.2%	11	6.7%	17	10.3%
Concerns that your teenager was using drugs or alcohol	132	80.0%	3	1.8%	3	1.8%	1	0.6%	12	7.3%	14	8.5%



Question 23: While you were living in Idaho when you had a teenager (ages 13 to 19 years old) did you ever need help with . . .												
Service	No, did not need help		Yes, needed help.....									
			But didn't seek help		Looked, but couldn't find		Found people and/or information but never used it		Found people and/or information to assist, but it was not helpful		Found people and/or information to assist and it was helpful	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Concerns that your teenager was not doing well in school	100	60.6%	9	5.5%	6	3.6%	2	1.2%	22	13.3%	26	15.8%
Concerns that your teenager could not sit still, focus on directions, or concentrate as well as other children his or her age	128	77.6%	3	1.8%	1	0.6%	1	0.6%	13	7.9%	19	11.5%
Concerns about whether your teenager was having sex	130	78.8%	7	4.2%	2	1.2%	2	1.2%	10	6.1%	14	8.5%
Concerns that your teenager may harm themselves	134	82.2%	4	2.5%	2	1.2%	1	0.6%	8	4.9%	14	8.6%
Concerns that your teenager may be physically or verbally abusive	138	84.2%	6	3.7%	3	1.8%	2	1.2%	5	3.1%	10	6.1%

Question 24: While residing in Idaho, and within the last 5 years, has anyone in your household ever needed help with any of the following . . .												
Service	Yes, needed help.....											
	No, did not need help		But didn't seek help		Looked, but couldn't find		Found people and/or information but never used it		Found people and/or information to assist, but it was not helpful		Found people and/or information to assist and it was helpful	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Concerns over feeling sad, blue or depressed	327	54.1%	56	9.3%	20	3.3%	11	1.8%	28	4.5%	162	26.8%
Concerns that someone may harm themselves	529	87.9%	13	2.2%	4	0.7%	1	0.2%	13	2.2%	42	7.0%
Concerns that someone may be physically or verbally abusive to others	522	86.9%	24	4.0%	7	1.2%	2	0.3%	9	1.5%	37	6.2%
Information on how to obtain public assistance such as food stamps, cash assistance, or emergency assistance programs	337	56.1%	12	2.0%	17	2.8%	6	1.0%	32	5.3%	197	32.8%
Family planning or birth control advice	408	68.3%	12	2.0%	2	0.3%	3	0.5%	12	2.0%	160	26.8%
Concerns over alcohol or drug abuse	530	89.1%	18	3.0%	6	1.0%	6	1.0%	11	1.9%	24	4.0%

Question 27: Experience using Idaho CareLine										
	Strongly Agree		Somewhat Agree		Neither Agree nor Disagree		Somewhat Disagree		Strongly Disagree	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
It has been helpful	75	47.2%	44	27.7%	22	13.8%	9	5.7%	9	5.7%
It provided resources that were accessible to someone living in my area of Idaho	70	46.1%	47	30.9%	18	11.8%	10	6.6%	7	4.6%
I was not eligible for the help that I was referred to	33	22.2%	17	11.4%	56	37.6%	15	10.1%	28	18.8%
The help that was offered addressed the problem I called the CareLine for	63	41.2%	42	27.5%	28	18.3%	9	5.9%	11	7.2%

## Idaho Families of Children With Special Health Care Needs Survey

Questions 7\_1, 7\_2, 8, 11

Question #7_1: Please indicate how much information you currently have in each area and how important you think this information is for families of children with special health care needs						
Type of Information	How Much information do you have on this topic?					
	Have Enough Information		Have Some but Need More		Need Much More Information	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
What care coordinator services are available to my family	59	54.1%	31	28.4%	19	17.4%
How to get care coordination services	56	51.4%	34	31.2%	19	17.4%
All health and support services available to families of children with special needs	41	37.6%	48	44.0%	20	18.4%
How to apply for Medicaid	83	76.9%	11	10.2%	14	13.0%
Information about the services covered by Medicaid	47	43.1%	38	34.9%	24	22.0%
Information about Katie Beckett health coverage	30	28.9%	13	12.5%	61	58.7%
Information about applying for SSI or other disability benefits	55	51.4%	26	24.3%	26	24.3%
What services are available to prepare for my child's transition to adulthood	27	25.5%	27	25.5%	52	49.1%
What needs to be done to keep Medicaid eligibility	45	42.1%	32	29.9%	30	28.0%
Information about parent support groups in my area	45	41.7%	29	26.9%	34	31.5%
Information about parent support groups around the country	45	41.7%	32	29.6%	31	28.7%

**Question #7\_2: Please indicate how much information you currently have in each area and how important you think this information is for families of children with special health care needs?**

Type of Information	How important is it for families of children with special needs to have information on this topic					
	Very Important		Somewhat Important		Not Important	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
What care coordinator services are available to my family	100	91.7%	8	7.3%	1	0.9%
How to get care coordination services	100	92.6%	8	7.4%		
All health and support services available to families of children with special needs	106	97.3%	2	1.8%	1	0.9%
How to apply for Medicaid	100	92.6%	5	4.6%	3	2.8%
Information about the services covered by Medicaid	100	91.7%	8	7.3%	1	0.9%
Information about Katie Beckett health coverage	84	81.6%	15	14.6%	4	3.9%
Information about applying for SSI or other disability benefits	93	87.5%	10	9.4%	3	2.8%
What services are available to prepare for my child's transition to adulthood	90	83.3%	15	13.9%	3	2.8%
What needs to be done to keep Medicaid eligibility	95	87.2%	8	7.3%	6	5.5%
Information about parent support groups in my area	80	73.4%	23	21.1%	6	5.5%
Information about parent support groups around the country	63	58.3%	33	30.6%	12	11.1%

Question #8: Please indicate how effective you think is each of the following ways of sharing information with families of children with special needs.						
Possible Ways to Obtain Information	How effective do you think it is . . .					
	Very Effective		Somewhat Effective		Not Effective	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
From a brochure or pamphlet	32	29.1%	74	67.3%	4	3.6%
From a care coordinator	87	79.1%	21	19.1%	2	1.8%
At a community meeting	27	25.0%	63	58.3%	18	16.7%
From parent support groups	60	55.1%	40	36.7%	9	8.3%
Have the local health department provide the information	50	46.3%	48	44.4%	10	9.3%
Through hospitals	57	52.3%	43	39.5%	9	8.3%
Over the Internet	54	50.0%	41	38.0%	13	12.0%
Call an 800 number	26	24.5%	57	53.8%	23	21.7%
Other-Please describe	9	60.0%	3	20.0%	3	20.0%

Question #11: How important are the following care coordination services to you, your child and your family?						
	How important do you think it is . . .					
	Very Important		Somewhat Important		Not Important	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
<b>Medical and Support Services Coordination</b>						
Coordination of child's medical care (doctor and hospital visits)	84	77.1%	11	10.1%	14	12.8%
Coordination of communication between doctors, hospital, and therapists	93	85.3%	10	9.2%	6	5.5%
Coordination of therapies	91	84.3%	8	7.4%	9	8.3%
Assistance applying for Medicaid	76	70.4%	23	21.3%	9	8.3%
Assistance keeping Medicaid coverage	78	72.2%	22	20.4%	8	7.4%
Assistance managing family finances	45	42.1%	37	34.6%	25	23.4%
Assistance applying for Katie Beckett health coverage	70	68.6%	20	19.6%	12	11.8%
Coordination of child's insurance coverage	80	74.8%	20	18.7%	7	6.5%
Access to ongoing up-to-date information about programs, services, and eligibility changes	101	92.7%	8	7.3%		
Assistance locating local parent support groups or parent support network	60	55.6%	40	37.0%	8	7.4%
Assistance locating out-of-state parent support groups or parent support network	39	36.1%	42	38.9%	27	25.0%
<b>Education Services Coordination</b>						
Understanding what is required of schools in regard to IEPs (Individual Education Plans)	90	83.3%	15	13.9%	3	2.8%
Assisting with development of child's IEP	89	83.2%	13	12.2%	5	4.7%
Assisting with coordinating IEP	86	80.4%	16	15.0%	5	4.7%
Coordinating child's physical care while at school	86	81.9%	15	14.3%	4	3.8%
Assistance accessing testing	86	81.1%	15	14.2%	5	4.7%
Assistance accessing and using therapies	88	83.8%	15	14.3%	2	1.9%
Understanding what is required of schools under special education laws and regulations	93	86.9%	12	11.2%	2	1.9%

## ***Appendix C: Focus Group Protocols***

---



## **Idaho Parents of Children Ages 0-8 Focus Group Moderator's Guide**

### **I. WELCOME/BACKGROUND INFO (10 minutes)**

Welcome to our group discussion. Thank you for taking the time to participate in our focus group discussion about young children. My name is \_\_\_\_\_, I am here with my colleague \_\_\_\_\_ and we work for Health Systems Research, Inc. based in Washington, DC. Our company is working with the Idaho Department of Health and Welfare. As a requirement for receiving Federal funding, Idaho and all other States are required to examine the needs of families and children in the State every five years.

As part of this needs assessment, they are seeking to learn more about the experiences of families with young children. This information will be used to assist them in improving services and resources for families.

The purpose of focus groups is to get the honest opinions of small groups of people about a specific topic. These topics may range from what people think about a particular soft drink, soap product, or in our case, services for young kids and their families.

I would like to review the ground rules for our discussion:

- There are no right and wrong answers. Remember, I do not work for the State of Idaho, so please tell me your thoughts, whether they are positive or negative.
- It is ok to disagree with one another. We want to hear everyone's point of view. If you disagree, please do so respectfully.
- Only one person should talk at a time. We are tape recording this session so that we do not miss anything important. If two people talk at once, we can not understand what anyone is saying. I may remind you of this during the group.
- We would like everyone to participate. You each do not have to answer every question. If, however, some of you are shy or I really want to know what you think about a particular issue, I may ask you about it.
- We have a lot that we want to talk about tonight. So, do not be surprised if at some point I interrupt the discussion and move to another topic. But, do not let me cut you off. If there is something important you want to say, let me know and you can add your thoughts in before we change subjects.
- We will be using first names only today. Everything you say is confidential. After we conduct several of these group discussions across the state, we will write a report for the Idaho Department of Health and Welfare. Your name will not appear anywhere in the report. What you say today will not be attached to your name at any point. Nothing that you say will affect your eligibility for or the services you receive

through any of the programs we talk about today.

- Do not worry about offending us. We really want to learn from you and find out what you think about the issues we talk about tonight. Please tell us your honest opinions.
- I want to make a couple more points related to the tape recording. Please speak up. If you speak too quietly, it will be too difficult to hear you later on the tape. Also, please do not bump the table or tap your hands on the table. Anything close to the microphones sounds incredibly loud on the tape and it will drown out your voices. \_\_\_\_\_ is also taking notes in case the tapes do not come out clearly and she will be handling the tape recorders.

The group will last two hours. You will not get out any later than \_\_\_\_\_. We will not be taking a formal break, but if you need to leave for a restroom break, the bathrooms are \_\_\_\_\_.

**(If someone unexpectedly came with a child and on-site child care was not arranged in advance:** If your child begins to get too noisy, please take them out of the room until they are quiet again. Then, come back into the room. Again, with tape recording, we need to keep the room relatively quiet.)

At the end of the session, we will give you \$20 cash for your time and expenses associated with coming tonight (child care and transportation). We will also ask you to complete a short anonymous survey.

## **II. INTRODUCTIONS**

**(5 minutes)**

Let's get started. Please remember that the focus of this group discussion is young children from birth to eight years old, so please limit your comments to that age group.

**Start with the participant to your right. Have them respond in round robin fashion.**

1. Please tell me your name, how many children you have, and their ages.

## **III. FOCUS GROUP QUESTIONS**

### **A. What Concerns Families About their Children Age Birth to Eight Years? (15 minutes)**

I would like to begin our discussion with some general questions about children age eight or younger.

1. What worries you about caring for and raising young children, that is babies and kids up to age 8?

Probe for:

- health needs (health insurance, finding a provider, cost of care, getting sick, safety issues - getting hurt)
- development (are they growing OK? Issues with eating, temper tantrums, sleep)
- who will take care of them (childcare arrangements, availability, cost, quality)
- family relationships (sibling rivalry, stress on family unit, current and future financial concerns)
- adequacy as a parent

2. What concerns you the *most*? Why?
3. Who do you turn to for help with things that worry you?

## **B. Pregnancy and Childbirth**

**(20 minutes)**

Now I would like those of you who are biological parents to think back to when you were pregnant.

1. What was good about the care you received when you were pregnant?
2. What could have been better?
3. How pregnant were you when you first started receiving care?

**Probe: [If they started care after the first trimester (the 4<sup>th</sup> month or later)]:**  
Any reasons you didn't see a doctor or nurse earlier?

4. While you were pregnant what information did you receive about what things would be like once you had a child? How helpful was this information?
5. Now I want you to think about when your child was born, where was your child born?
6. What was this experience like?

Probe: What was good about it? What could have been better?

7. After your child was born what follow-up care did you receive? What was good about it? What could have been better?
8. What help and support were you offered with breastfeeding? What help and support could you have used that you didn't receive?

### C. Healthcare

(20 minutes)

I want to turn to the healthcare you receive for your child or children.

1. First I have a question about health insurance. Can you raise your hand if your child has health insurance coverage? What is good and what is bad about the health insurance coverage you have for your child?
2. **(If anyone does not have coverage)** What has been your experience in obtaining health care without insurance?
3. **(For everyone)** Are you able to see a doctor when you feel you need to?

Listen for:

- issues related to finding, paying, timeliness of availability
- other barriers (e.g. transportation)

4. During visits what does the doctor or nurse talk with you about?

Probe for:

- child development (Does the doctor tell you what age you can expect your child to accomplish a particular task)
- child rearing (eating, sleeping, play, temper tantrums)
- family concerns (stress on parent, sibling rivalry)
- does the doctor suggest and/or refer you to other resources or services?

5. What kinds of things *would* you like to discuss with your child's health care provider?

Listen for:

- health issues, development, parenting advice, resource information, family issues, behavioral issues, and level of comfort with talking with provider

6. If you could change one thing about the healthcare you receive for your child what would it be?

### D. PARENTING

(20 minutes)

Now let's go on and talk about parenting. Babies and young children do not come with instruction manuals, let's talk about how and where you learn to be a parent starting with:

1. Where do you go to for answers about your parenting questions or concerns?

Probe for:

- What information or advice they were seeking
- How useful was the information or advice
- What made it useful

2. What are the child rearing areas and issues where you think parents and families need the most information and guidance?

3. What services in your community currently help parents in these areas?

Probe for:

- What are they look like?
- What is good and bad about them?

4. What services are needed that aren't currently available?

Probe for:

- What should they look like?
- What are some strategies that could be used to help parents strengthen their parenting skills?

## **E. FAMILY SUPPORT**

**(15 minutes)**

Caring for little ones, managing a home and supporting a family can be a handful and sometimes parents need some help.

1. What kinds of supports do families of young children need?

(Try not to use but if parents get stuck and need some explanation: "these are programs or services which help parents raise their children or help with particular family issues, including things such as financial issues, stress, parent support groups, balancing work and family")

2. What kinds of supports are currently available to families in your community?

3. How could these supports and services be improved?

4. What is the best way to for people to learn about family support issues and services available in the community?

Probe: Community meetings or lunches? Mailings? Email? The internet?  
Flyers in doctor's offices or daycare?

## **C. SUMMARY ISSUES**

**(15 minutes)**

1. Thinking about all the areas and services we have discussed, what would make it easier for you and your family to:

a) Do a good job raising your children?

- b) Feel more confident in raising your children?
- c) Find services needed?
- d) Use services needed?

Probe for: warm lines, info directories, co-located services, Family Centers, services connected to church, childcare/Head Start, health care,

- 2. If there was one thing you could change about the services available in your community to parents of very young children, what would it be?
- 3. What is the best part of being a parent to children under age 5?  
(want to end with happy thoughts)

#### **IV. CLOSING**

**(5 MINUTES)**

Check for questions or follow-up from co-moderator.

Thank you very much for coming tonight. We enjoyed the discussion and have learned a lot from your comments and suggestions.

Is there anything I haven't asked about that you would like to tell me related to the topics we have discussed?

Please complete the form with a few questions about you.....be sure NOT to include your name. Also please sign a receipt for the \$30.

Idaho  
CSHCN Focus Group  
Moderators Guide

A. INTRODUCTION

(10 MINUTES)

Welcome to our group discussion. Thank you for taking the time to participate in this discussion to share your thoughts and experiences around services for children with special needs. By that we mean children and adolescents with a chronic health problem, behavioral problem, or disability. My name is \_\_\_\_\_ and I work for Health Systems Research. My co-worker's name is \_\_\_\_\_. Our company is working with the Idaho Department of Health and Welfare. As a requirement for receiving Federal funding, Idaho and all other States are required to examine the needs of families and children in the State every five years.

As part of this needs assessment they are seeking to learn more about the experiences of families of children with special needs. This information will be used to assist them in improving services and resources for children and teens with special needs.

This discussion is called a “focus group.” The purpose of focus groups is to get the honest opinions of small groups of people about a specific topic. These topics may range from what people think about a particular soft drink, soap product, or in our case, services for children with special needs.

I would like to review the ground rules for our discussion:

- There are no right and wrong answers. Remember, we don't work for any state agency, so please tell us what you honestly think.
- It is OK to disagree with one another. We want to hear everyone's point of view. If you disagree, please do so respectfully.

Only one person should talk at a time. We are tape recording this session so that we don't miss anything important. If two people talk at once, we can't understand what anyone is saying. We may remind you of this during the group.

- We would like everyone to participate. But, you each don't have to answer every question. If, however, some of you are shy or I really want to know what you think about a particular question, I may call on you.
- We have a lot that we want to talk about tonight. So, don't be surprised if at some point we interrupt the discussion and move to another topic. But, don't let us cut you off. If there is something important you want to say, let us know and you can add your thoughts in before we change subjects.
- We want to talk with you about services for children with special needs. Also, we are more interested in some aspect of the topic than others. If the group starts to talk

about any other issues, we will remind you to stay on topic.

- We will be using first names only today. Everything you say is confidential. After we conduct several of these group discussions across the state, we will write a report to the Idaho Department of Health and Welfare. Your name will not appear anywhere in the report. What you say today will not be attached to your name at any point. **Nothing that you say will affect the services you receive now or in the future.**
- We really want to learn from you and find out what you think about the issues we talk about. Please tell us your honest opinions.
- We want to make a couple more points related to the tape recording. Please speak up. If you speak too quietly, it will be too hard to hear you later on the tape. Also, please don't bump the table or tap your hands on the table. Anything close to the microphones sounds incredibly loud later on and it will drown out your voices.
- \_\_\_\_\_ is taking notes in case the tapes don't come out clearly and she will be handling the tape recorders. At the end of the session, she will provide a brief summary of what you all said tonight, so that you can correct anything we have misunderstood or clarify important points.

The group will last no more than two hours. You will not get out any later than \_\_\_\_\_. We will not be taking a formal break. If you need to leave for a restroom break, the bathrooms are \_\_\_\_\_.

**If someone unexpectedly came with a child and on-site child care was not arranged in advance:** If your child begins to get too noisy, please take them out of the room until they are quiet again. Then, come back into the room. Again, with tape recording, we need to keep the room relatively quiet.

At the end of the session, we will give you \$20 cash for your time and expenses associated with coming tonight (child care and transportation). We will also ask you to complete a short anonymous demographic form that asks some basic information about your family.

Let's get started. I'd like to start out by going around the table and having each of you tell us a little about yourself. Again, my name is \_\_\_\_\_.

**Start with the participant to your right. Have them respond in round robin fashion.**

## **B. CURRENT UTILIZATION OF SERVICES**

**(30 MINUTES)**

1. Please tell me your name, how many children you have and their ages, and what kind of insurance you have. We are particularly interested in your experiences caring for your child with special needs (child with a chronic health or disabling condition) so would you tell us the nature of your child's special need.
2. Who would you consider to be your child's primary/regular doctor?



Probe:

- A specialist, a primary care/pediatrician?
- Has your child's primary doctor changed over the years?

3. In addition to your primary doctor, what are the other health care providers that you have used for your child/teen in the last year?

Probe:

- specific medical specialists
- OT, PT, Speech therapist
- dentist
- nutritionist
- counselor, mental health
- walk-in clinics
- emergency room
- local public health department
- other

4. What other (non-medical) services have you used for your child or teen in the past year?

Probe:

- education
- social services
- counseling/mental health
- support
- respite

5. What have been your experiences in obtaining day care or schooling for your child?

Probe:

- What has worked well about this?
- What could be better?

6. Does your child or teen need medical care while at school? At day care?

Probe:

- What kind?
- How is this managed?

## **C. SURVEILLANCE AND INITIAL ASSISTANCE**

**(20 MINUTES)**

Please think back to when you found out your child had a special need.

1. Can you describe how you found out?
2. What help were you offered in understanding what your child would need at that point?

3. What services were you connected to?
4. What helped were you offered in terms of how this affected your family?
5. Thinking of all that happened when you first found out about your child's special needs, what was useful about the help you received? What could have been better?

**D. SEEKING SERVICES AND CARE COORDINATION (45 MINUTES)**

1. What have been your experiences in finding the services your child needs?

Probe:

- Explore experiences with different agencies/systems (education, early intervention, medical [primary care, specialty care], nutrition, pharmacy, durable medical equipment, supplies, etc.)

2. Who helps you find the services your child needs?

Probe :

- Primary doctor?
- Does family do this - if so who?
- An agency (education, social services)?
- Various agencies depending on need or service? If so, who is the *most* involved?

3. What help do you receive in determining and understanding what services your child needs?
4. What do you feel is working well within your community in regards to finding, determining and understanding the services your child needs?
5. What makes it hard to get services for your child or teen?

Probe:

- Availability of services/providers
- Accessibility of services/providers
- Lack of knowledgeable providers
- Health Insurance Issues/out-of-pocket costs

6. What is the *most* serious problem you and your family face in trying to get and use care for your child with special needs and your family?

Probe:

- Lack of communication, coordination, or cooperation between service providers
- Cost of services
- Problems finding home or community-based services
- Problems scheduling services or getting/using appointments (wait times)
- Not knowing what services are available
- Needed services are not available in my community
- Geographic distance to service
- Lack of reliable transportation

7. What would make it easier to get/use care for your child or teen?

Probe:

- Having one person to assist family with coordination of care
- Having multiple services available in one place
- Having one place to get information about services and financing of care

8. What *one* thing would make the system better for you and your family?

9. Caring for a child or teen with special needs can affect the entire family. Tell if you agree or disagree with the following statements.

a) My child's health problems are causing financial problems for our family.

b) My child's health conditions are causing disagreements within our family.

c) I need additional support to care for my child.

d) I have cut down the hours I work or have stopped working because of my child's health condition.

e) (If has not surfaced) What are the positive impacts on the family of caring for a special needs child?

10. What is the *one* thing that would help the impact on your family of caring for your child or teen with a special need?

## E. CLOSING

(10 MINUTES)

Thank you very much for coming. We enjoyed the discussion and have learned a lot.

Is there anything I haven't asked about that you would like to tell me about?

Ask the co-moderator if they have any questions.

Have participants complete short demographic form.

Pass out the envelopes with the \$20 and ask them to sign a sheet saying they got their money.

Encourage them to take home whatever food remains.

# Idaho Adolescent Health Focus Groups

## Teen Protocol

### I. BACKGROUND

(10 MINUTES)

Welcome to our group today. Thank you for taking the time to participate in this afternoon's discussion. My name is \_\_\_\_\_ and I work with Health Systems Research. My co-worker's name is \_\_\_\_\_. The State of Idaho's Division of Health is interested in finding out more about your opinions of the health care services and supports available to you. Your ideas will be used to educate providers on the types of health issue teenagers have, and what types of services they want to meet their needs.

I would like to review the ground rules for our discussion:

- There are no right or wrong answers. Remember, I don't work for the State of Idaho, the Idaho Migrant Council, the county, or the school system. I will not be speaking to your parents so please tell me your thoughts, whether they are positive or negative.
- It is ok to disagree with one another. We want to hear everyone's point of view. If you disagree, please do so respectfully.
- Your participation in today's focus group is voluntary. You are free to leave at any time. However, pizza will be served midway through our meeting and the \$20 in cash will only be given to those who stay until the end.
- Only one person should talk at a time. We are tape recording this session so that we don't miss anything important. If two people talk at once, we can't understand what anyone is saying. I may remind you of this during the group.
- I would like everyone to participate. But, you each don't have to answer every question. You don't have to raise your hand either. If, however, some of you are shy or I really want to know what you think about a particular question, I may call on you.
- I have a lot that I want to talk about this afternoon. So, don't be surprised if at some point I interrupt the discussion and move to another topic. But don't let me cut you off. If there is something important you want to say, let me know and you can add your thoughts in before we change subjects.
- We will be using first names only today. Everything you say is confidential. We will write a report for the State to use in its adolescent health planning. Your name will not appear anywhere in the report. We also ask that you don't tell other people what was said by specific people during the group. What you say today will not be attached to your name at any point. Nothing that you say will be repeated to teachers or your parents.

- Don't worry about offending me. I don't have a vested interest in anything that is said here tonight. I really want to learn from you and find out what you think about the issues we talk about this afternoon. Please tell me your honest opinions.
- As I mentioned the session is being recorded, in order to ensure that the tapes are as clear as possible I would ask that you do not tap on the table and that you speak up when you talk.

The group will last two hours. We will need to talk while you are eating later so that the group ends on time. We will not be taking a formal break. If you need to leave for a restroom break, the bathrooms are \_\_\_\_\_.

Do you have any questions before we begin?

## II. INTRODUCTIONS

(5 MINUTES)

Let's get started. I'd like to start out by going around the table and having each of you tell us a little about yourself. Again, my name is \_\_\_\_\_.

*Start with the participant to your right. Have them respond in round robin fashion.*

1. Please tell me your name, how old you are, and what you most like to do for fun?

## III. FOCUS GROUP QUESTIONS

(15 MINUTES)

### A. TEEN ATTITUDE ON HEALTH CARE

I would like to begin today's discussion with some general questions about being a teenager.

1. What are some of the things that you worry about as a teenager (*Listen for health and health insurance issues*)?
2. What do you think are your parent's/guardian's biggest worries about you?
3. What types of health services do you think are most important for teens your age?

PROBE: What are some reasons why you or your friends go to the doctor or nurse?

4. How do people stay healthy?

### B. HEALTH ACCESS

(20 MINUTES)

1. When you have questions about a health issue, where do you go for information?
2. What do you do when you don't feel well? (*Listen for what kids do/try, self-care, etc.*)

PROBE: Who usually makes the decision on whether or not you go to the doctor?

PROBE: Where do you go?

- Do you go to your parents doctor or clinic?
  - Do you go to the school nurse?
  - What is it about that place that makes you want to go there for health care?
3. If you could create the perfect doctor's office or clinic to go to what would it be like?

PROBE: How do you want them to treat you?

- What kinds of services or information would you want them to have?
  - What would you want them to say? What would you ***not*** want them to say--
  - Have any of your peers ever delayed seeing a health care provider because of fear that their parents would find out? (*Listen for confidentiality issues*)
4. If you want to see a doctor or nurse, what are some of the things that make it hard for you to get in to see them? What makes it easy for you?
5. What about dental care? Are you able to see the dentist when you need to?

## C. HEALTH TOPICS

(45 MINUTES)

Now I would like to focus in more detail on some of the areas we have touched on and ask you about your thoughts and experiences.

### 1. Let's begin with one of my favorite topics – food! (and exercise)

- 1.1 What are some of your favorite foods and snacks?
- Which of these foods do you consider 'healthy'?
- 1.2 What do you see as the benefits of eating healthy?
- 1.3 If you wanted to eat more healthy foods, what one thing would you want to change now?
- 1.4 Where do you get information about food or nutrition? Do you believe the information?
- 1.5 What exercise/physical activity are you already doing?
- 1.6 What are some of the reasons teens don't exercise? What kinds of exercise/physical activity would you like to do or be interesting in doing?

1.7 How would you find out about what is available?

## **2. Now let's move on to alcohol, drug and tobacco use.**

2.1 At what age do youth in your community start drinking or using drugs?

2.2 What percent of the teenagers you know drink or use drugs?

2.3 What are some of the reasons that people start drinking or using drugs?

2.4 What percent of the teenagers you know smoke cigarettes or use chewing tobacco?

2.5 Thinking about other Hispanic teens you've known who did not use drugs or alcohol... Why Didn't they (Prompt: What was it about them, their family, or their environment?)

2.6 What could be done to keep kids from drinking, taking drugs, smoking cigarettes, or chewing tobacco?

## **3. Reproductive Health**

3.1 Do you think teen pregnancy is a problem in your community? Why or why not?

3.2 Where do young people get information about preventing pregnancy? Do you trust the information?

3.3 What information do you have to prevent sexually transmitted diseases such as chlamydia, gonorrhea, syphilis or AIDS?

## **4. Emotional Health**

4.1 If kids are feeling really, really sad or angry or worried what do they usually do?

PROBE: Who can they talk to?

Where can they find help?

Is there anything that can be done to better help kids who feel this way?

## **5. Violence**

5.1 What types of violence do the young people in your community experience or witness? PROBE: At home? In school? At work?

5.2 What do you think could be done to reduce violence?



## **E. HEALTH CARE PROMOTION**

**(15 MINUTES)**

We want to get your opinions on the best ways for health and social service groups to reach teens.

1. What's the best way to reach teenagers for groups that want to help young?

PROBE: Where do teens like to go to hangout?

What do teens like to do?

- Magazines?
- Radio stations?

2. Tell me about any health-related activities or programs that you participated in or heard about.

PROBE: What is it about that activity or program that made it stand out?

Would you participate in it again?

What is it about that activity or program that would make you want to participate in it or not participate in it again?

3. Be creative – tell me what other kinds of health programs or activities would be most interesting to you or your friends?

PROBE: Have you ever signed up or participated in something for the incentives or giveaways?

-What was the incentive/giveaway?

- Money?
- Food?
- T-Shirts?

## **F. CONCLUSION**

**(10 MINUTES)**

1. If you could change one thing about how health care services are provided to teens, what would it be and why?
2. Is there any other information you would like to share about teenagers in your community?

I want to thank you for participating in the group today. The confidential information you have provided will be of great help to the State of Idaho as it makes plans to improve the health care of all teenagers in the state. We appreciate you taking the time to share your opinions with us and we wish you good luck and good health. I have envelopes to give you with your \$20 to thank you for your time.

## ***Appendix D: Bibliography***

---

# ***Bibliography***

## ***Chapter I: No Citations***

## ***Chapter II: No Citations***

## ***Chapter III: Idaho Demographics and Family Security***

DeNavas-Walt, C., Proctor, B., and Mills, R. (2004). Income, Poverty, and Health Insurance Coverage in the United States: 2003, Current Population Reports, P60-226. Washington, DC: U.S. Census Bureau.

Frontier Education Center. (2004). 2000 Update: Frontier Counties in the United States. National Clearinghouse for Frontier Communities. Retrieved March 30, 2005 from, <http://www.frontierus.org/index.htm?p=2&pid=6003&spid=6018>

Hall, B. (2001). Bring the Harvest Home: Hunger in Idaho and What State Leaders Can Do About It. Boise, ID: Idaho Community Action Network (ICAN) and Seattle, WA: Northwest Federation of Community Organizations (NWFCO).

Himmelstein, D., Warren, E., Thorne, D., and Woolhandler, S.(2005). MarketWatch: Illness and injury as contributors to bankruptcy. *Health Affairs*. [Epub ahead of print, Feb 2, 2005]. Retrieved March 30, 2005 from, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1>

Idaho Department of Health and Welfare. (1999). Idaho's Health: A Summary of Health Factors, Status, Systems, and Services. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics.

Idaho Department of Health and Welfare. (2004). Idaho Vital Statistics 2002. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Housing and Finance Association and Idaho Department of Commerce. (2000). Five-Year Strategic Plan for Housing and Community Development: Idaho 2000-2004. Retrieved March 30, 2005 from [http://www.ihfa.org/pdfs/2000\\_Idaho\\_Strategic\\_Plan.pdf](http://www.ihfa.org/pdfs/2000_Idaho_Strategic_Plan.pdf)

Idaho Housing and Finance Association. (2001). 2001 State of Idaho's Housing Needs: Summary and Strategies. Retrieved March 30, 2005 from, [http://www.ihfa.org/pdfs/IHFA\\_HN2001.pdf](http://www.ihfa.org/pdfs/IHFA_HN2001.pdf)

Idaho State Planning Grant. (2001). Idahoans Without Health Insurance: A Data Report. Idaho Department of Commerce. Retrieved March 30, 2005 from, <http://www.idahouninsured.org/ispg10.30.pdf>

Kaiser Family Foundation. (2004). Individual State Profiles: Idaho. Retrieved November 12, 2004 from, [http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=At%2dA%2dGlance&subcategory=&topic=&link\\_category=&link\\_subcategory=&link\\_topic=&welcome=0&area=Idaho](http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=At%2dA%2dGlance&subcategory=&topic=&link_category=&link_subcategory=&link_topic=&welcome=0&area=Idaho)

Koball, H. and Douglas-Hall, A. (2004). Receipt of Government Supports Varies Widely by State. National Center for Children in Poverty, Columbia University Mailman School of Public Health. Retrieved March 30, 2005 from, <http://www.nccp.org/media/svf04b-text.pdf>

Morrill, W.(1992). Overview of service delivery to children. *School-Linked Services* 2(1):32-43.

National Center for Children in Poverty. (2005a). 50-State Demographic Wizard. Columbia University Mailman School of Public Health. Retrieved March 30, 2005 from, [http://www.nccp.org/wizard/wizard.cgi?action=reset&output\\_page=B](http://www.nccp.org/wizard/wizard.cgi?action=reset&output_page=B)

National Center for Children in Poverty. (2005b). Section 8 Housing Vouchers: Trend Data. Columbia University Mailman School of Public Health. Retrieved March 30, 2005 from, [http://www.nccp.org/policy\\_cross\\_state.html](http://www.nccp.org/policy_cross_state.html)

National Rural Health Association. (2005). Health Insurance Access in Rural America, Policy Brief, March 2004. Retrieved March 30, 2005 from, <http://www.nrharural.org/dc/policybriefs/insurance.pdf>

Northwest Area Foundation. (2005). Indicators for Idaho. Retrieved March 30, 2005 from, <http://www.indicators.nwaf.org/ShowOneRegion.asp?FIPS=16000>

Northwest Federation of Community Organizations and Sommers, P. (2004). Searching for Work that Pays: The Northwest Job Gap Study. Retrieved March 30, 2005 from, [http://www.nwfco.org/idaho\\_factsheet.pdf](http://www.nwfco.org/idaho_factsheet.pdf)

Office of Family Assistance. (2002). Fiscal Year 2001: Characteristics and Financial Circumstances of TANF Recipients. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Family Services. Retrieved March 30, 2005 from <http://www.acf.hhs.gov//programs/ofa/character/FY2001/characteristics.htm>

Substance Abuse Social Indicators. (2004). State of Idaho Substance Abuse Social Indicators Web Page. Retrieved March 30, 2005 from, [http://www.class.uidaho.edu/sasi/State\\_Totals/totals\\_food\\_stamps.htm](http://www.class.uidaho.edu/sasi/State_Totals/totals_food_stamps.htm)

Sullivan, A. and Eunyoung, C. (2002). Hunger and Food Insecurity in the Fifty States: 1998-2000. Food Insecurity Institute, Center on Hunger and Poverty, Heller School for Social Policy & Management, Brandeis University. Retrieved March 30, 2005 from, <http://www.centeronhunger.org/pdf/statedata98-00.pdf>

Snyder, T., Tan, A., and Hoffman, C. (2004). Digest of Education Statistics, 2003. Washington, DC: U.S. National Center for Education Statistics.

Turner, S. (2004). Environmental Assessment for the State of Idaho: A Guide to Idaho's Community Development Landscape. Federal Reserve Bank of San Francisco, Community Affairs Department. Retrieved March 30, 2005 from, <http://www.frbsf.org/community/research/idaho.pdf>

U.S. Census Bureau. (1991). 1990 Census of Population and Housing, Summary Tape File 1 [Idaho]. Washington, DC: U.S. Census Bureau.

U.S. Census Bureau. (2001). Census 2000 Summary File 1 [Idaho]. Washington, DC: U.S. Department of Commerce.

U.S. Census Bureau. (2004). 2003 American Community Survey [Idaho]. Washington, DC: U.S. Department of Commerce.

### ***Chapter IV: Idaho Health Care Infrastructure***

All Star Directories. (2005). Idaho Nursing Schools. Retrieved March 31, 2005 from, <http://www.allnursingschools.com/find/Idaho/nursing-schools.php>

Bureau of Primary Health Care. (2005). MUA/MUP Database. U.S. Department of Health and Human Services, Health Resources and Services Administration. Retrieved March 31, 2005 from, <http://bphc.hrsa.gov/databases/newmua/default.cfm>

Hartley, D. and Gale, J. (2003). Rural Health Care Safety Net. Part 3, Chapter 9 in Tools for Monitoring the Health Care Safety Net. Weinick, R. and Billings, J., eds. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality Research. Retrieved March 31, 2005 from <http://www.ahrpr.gov/data/safetynet/tools.htm>

Idaho CareLine. (2004). Reports, Forms and Demographics. Retrieved December 12, 2004 from [http://www.idahocareline.org/Reports\\_homeB.htm](http://www.idahocareline.org/Reports_homeB.htm)

Idaho Department of Education. (2004). Part B Annual Performance Report: Status of Program Performance [Electronic version]. Retrieved March 31, 2005 from, <http://www.sde.state.id.us/specialed/docs/partbannualperformance.pdf>

Idaho Department of Health and Welfare. (1999). Idaho's Health: A Summary of Health Factors, Status, Systems, and Services. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics.

Idaho Department of Health and Welfare. (2004a). Road to the Future: Strategic Plan FY 2005-2008, Publication No. HW-0010. Boise, ID: Idaho Department of Health and Welfare, Division of Health.

Idaho Department of Health and Welfare. (2004b). Idaho Primary Health Care, Dental, and Mental Health Professional Shortage Service Areas. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Office of Rural Health and Primary Care. Unpublished data.

Idaho Department of Health and Welfare. (2004c). Idaho Medically Underserved Areas/Medically Underserved Populations. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Office of Rural Health and Primary Care. Unpublished data.

Idaho Hospital Association. (2004). 2004 Membership Directory. Boise, ID: Idaho Hospital Association.

Idaho Legislative Services Office. (2001). Idaho Fiscal Facts 2001: A Legislator's Handbook of Facts, Figures and Trends. Boise, ID: Idaho Legislature, Legislative Services Office, Budget and Policy Analysis. Retrieved March 31, 2005 from, <http://www.legislature.idaho.gov/Budget/publications/PDFs/FiscalFacts/FF2001.pdf>

Idaho Legislative Services Office. (2004). Idaho Fiscal Facts 2004: A Legislator's Handbook of Facts, Figures and Trends. Boise, ID: Idaho Legislature, Legislative Services Office, Budget and Policy Analysis. Retrieved March 31, 2005 from, <http://www.legislature.idaho.gov/Budget/publications/PDFs/FiscalFacts/FY2005/FFFrame.htm>

Idaho Primary Care Association. (2005). Find a CHC. Retrieved March 31, 2005 from, <http://www.idahopca.org/chc/find.php>

Idaho Public Health Districts. (2004). Idaho's Public Health Districts: Strategic Plan 2005- 2003 Report.

Kaiser Family Foundation. (2005a). Idaho: Federal Matching Rate (FMAP) for Medicaid. Retrieved March 28, 2005 from, [http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Federal+Matching+Rate+\(FMAP\)](http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Federal+Matching+Rate+(FMAP))

Kaiser Family Foundation. (2005b). Idaho: Distribution of Medicaid Spending per Enrollee by Enrollment Group, FY2000. Retrieved March 28, 2005 from, <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Spending+per+Enrollee+by+Group%2c+FY2000>

Kaiser Family Foundation. (2005c). Idaho: Medicaid & SCHIP. Retrieved March 30, 2005 from, <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Medicaid+%26+SCHIP&printerfriendly=1&subcategory=&topic=>

Kaiser Family Foundation. (2005d). Idaho: Total Hospitals, 1999-2002. Retrieved March 30, 2005 from, <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Providers+%26+Service+Use&subcategory=Hospital+Trends&topic=Total+Hospitals%2c+1999%2d2002>

Kaiser Family Foundation. (2005e). Idaho: Providers & Service Use. Retrieved March 30, 2005 from <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Providers+%26+Service+Use>

Kaiser Family Foundation. (2005f). Idaho: Distribution of Revenue by Source for Federally Qualified Health Centers, 2003. Retrieved March 31, 2005 from, <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Providers+%26+Service+Use&subcategory=Federally+Qualified+Health+Centers&topic=Distribution+of+Revenue+by+Source>

Kaiser Family Foundation. (2005g). Idaho: Number of Rural Health Clinics, 2004. Retrieved March 31, 2005 from, <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Providers+%26+Service+Use&subcategory=Rural+Health+Clinics&topic=Total+Health+Clinics>

Kaiser Family Foundation. (2005h). Idaho: Distribution of Nonfederal Physicians by Race, 2003. Retrieved March 31, 2005 from <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Providers+%26+Service+Use&subcategory=Physicians&topic=Nonfederal+Physicians+by+Race>

Office of Family Assistance. (2004). TANF Financial Data. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Family Services. Retrieved March 31, 2005 from [http://www.acf.hhs.gov/programs/ofs/data/tableA\\_spending\\_2003.html](http://www.acf.hhs.gov/programs/ofs/data/tableA_spending_2003.html)

National Association of Community Health Centers. (2003). Health Center Fact Sheet: Idaho. Retrieved March 31, 2005 from, <http://www.nachc.com/research/files/idahofactsheet.pdf>

National Health Statistics Group. (2004). United States Personal Health Care Expenditures (PHCE), All Payers 1980-2000. Baltimore, MD: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary.

Northwest Portland Area Indian Health Board. (2005). Tribal Health Stats. Retrieved March 31, 2005 from, [http://www.npaihb.org/profiles/tribal\\_profiles/NWTribalHealthStats.htm](http://www.npaihb.org/profiles/tribal_profiles/NWTribalHealthStats.htm)

U.S. Census Bureau. (2004a). 2003 American Community Survey [Idaho]. Washington, DC: U.S. Department of Commerce.

U.S. Census Bureau. (2004b). Statistical Abstract of the United States: 2004-2005 (124<sup>th</sup> Edition). Washington, DC: U.S. Department of Commerce.

U.S. Census Bureau. (2004c). Consolidated Federal Funds Report for Fiscal Year 2003. Washington, DC: U.S. Department of Commerce.

## ***Chapter V: Pregnant Women and Mothers***

The Alan Guttmacher Institute. (2000). Executive Summary: Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics. Retrieved October 17, 2004 from [http://www.agi-usa.org/pubs/ftp\\_exec\\_sum.html](http://www.agi-usa.org/pubs/ftp_exec_sum.html)

The Alan Guttmacher Institute. (2004). Contraception Counts, Idaho. Retrieved October 17, 2004 from [http://www.guttmacher.org/pubs/state\\_data/states/idaho.html](http://www.guttmacher.org/pubs/state_data/states/idaho.html)

American Academy of Pediatrics. (2004). POLICY STATEMENT, Hospital Stay for Healthy Term Newborns, American Academy of Pediatrics, Committee on Fetus and Newborn Pediatrics. *PEDIATRICS* Vol. 113 No. 5 May 2004, pp. 1434-1436

American Diabetes Association. (2005). Diabetes Statistics for Native Americans. Retrieved January 15, 2005 from the American Diabetes Association web site  
<http://www.diabetes.org/diabetes-statistics/native-americans.jsp>

Beck LF, Johnson CH, Morrow B, Lipscomb LE, Gaffield ME, Colley Gilbert B, Rogers M, Whitehead N. (2003). PRAMS 1999 Surveillance Report. Atlanta, GA: Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Brett KM, Hayes SG. (2004). Women's Health and Mortality Chartbook. Washington, DC: DHHS Office on Women's Health.

Brown, S.S., and Eisenberg, L., eds. (1995). *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*. Washington, DC: National Academy Press.

Caiazza, A., Shaw, A. eds. (2004). *The Status of Women in Idaho*, Institute for Women's Policy Research.

Department of Health and Human Services. (2004). *Women's and Minority Health Database, 2003-2004*, Washington, DC.: Office of Public Health and Science, Office on Women's Health.

Dye, T.D., Wojtowycz, M.A., Aubry, R.H., et al. (1997). Unintended pregnancy and breast-feeding behavior. *American Journal of Public Health* 87(10):1709-1711.

Family Planning Program.(2004.) Unpublished analysis of Family Planning Program Data. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical and Preventive Services.

Finer LB and Henshaw SH (2003). Abortion incidence and services in the United States in 2000, *Perspectives on Sexual and Reproductive Health*, 35(1):6-15.

Frazao, E. ed. (1999). The high costs of poor eating patterns in the United States. *American's Eating Habits: Changes and Consequences*. Washington, DC: U.S. Department of Agriculture, Economic Research Services, AIB-750.

Gold, R. (2004). Doing More for Less: Study Says State Medicaid Family Planning Expansions Are Cost-Effective. *The Guttmacher Report on Public Policy*, Volume 7, Number 1, March 2004.

Hakes, D., Blanco, J., Foxcroft, B., Compean-Rincon, J., Sanchez, A. (2003). Health Care Access Barriers for Idaho Latinos Focus Group Results, Idaho Primary Care Association.



Hovey JD, Magana CG. (2002). Psychosocial predictors of anxiety among immigrant Mexican migrant farmworkers: implications for prevention and treatment. *Culture Divers Ethnic Minor Psychol.* 2002 Aug;8(3):274-89.

Idaho Department of Health and Welfare. (2000). Idaho Vital Statistics 2000. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Department of Health and Welfare. (2001). Idaho Vital Statistics 2001. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Department of Health and Welfare. (2003a). Idaho Behavioral Risk Factors: Results From the 2002 Behavioral Risk Factor Surveillance System. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Department of Health and Welfare. (2003b). Mental Health Risks of Idaho Adults 2001, Analysis from the Behavioral Risk Factor Surveillance System. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Department of Health and Welfare. (2004a). Idaho Vital Statistics 2002. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Department of Health and Welfare. (2004b). Idaho Behavioral Risk Factors: Results From the 2003 Behavioral Risk Factor Surveillance System. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Department of Health and Welfare. (2004c). Birth outcomes 2001-2003 stratified by race, age, county, etc. Boise, ID: Idaho Department of Health and Welfare, Bureau of Health Policy and Vital Statistics. Unpublished Data.

Idaho Department of Health and Welfare. (2004d). Monitoring Perinatal Depression in Idaho Using the Pregnancy Risk Assessment Tracking System (PRATS). Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Department of Health and Welfare. (2005a). 2001 PRATS (Pregnancy Risk Assessment Tracking System). Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Department of Health and Welfare. (2005b). FACTS/FIGURES/TRENDS/2004-2005, Boise, ID.

Idaho Department of Health and Welfare. (2005c). Idaho Postpartum Depression Hospital-Based Support Groups. Retrieved on January 30, 2005 from <http://www.healthandwelfare.idaho.gov/DesktopModules/Articles/ArticlesView.aspx?TabID=0&Alias=Rainbow&Lang=en-US&ItemID=508&mid=10441>

Idaho Diabetes Prevention and Control Program. (2004). Diabetes in Idaho - A Summary Report 2002. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Community and Environmental Health.

Idaho Head Start Association. (2004). Summary 2003- Idaho Head Start Program information report. Boise, ID. Unpublished Data.

Idaho State Police. (2003a). Assessing the Drug Problem in Idaho by County: A Survey of Criminal Justice Practitioners, A Descriptive Report. Meridien, Idaho: Idaho State Police, Planning, Grants and Research, Statistical Analysis Center, Bryne Evaluation Unit.

Idaho State Police. (2003b). Intimate Partner Violence: A NIBRS Analysis Including Victimization Survey Correlations. Meridien, Idaho: Idaho State Police, Statistical Analysis Center.

Idaho Women's Health Check Program. (2004). Unpublished analysis of Women's Health Check Program Data. Idaho Department of Health and Welfare, Bureau of Clinical and Preventive Services.

Idaho Women, Infants and Children [WIC] Program. (2002). Nutrition Surveillance Report of the Idaho WIC Program. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical and Preventive Services.

Johnson, C., Johansen, H. (2004). Breast and Cervical Cancer in Idaho. Power point presentation for the Idaho Breast & Cervical Cancer Alliance, Partnerships & Patient Focused Care, April 29-30, 2004, Cancer Data Registry of Idaho, Women's Health Check.

The Kaiser Family Foundation. (2001). Women's Health Policy Facts: Women's Health Insurance Coverage. Retrieved March 31, 2005 from <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13898>

The Kaiser Family Foundation. (2003). University of California at Berkeley analysis of the Behavioral Risk Factor Surveillance System, 2003, unpublished data. Retrieved November 12, 2004 from <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?>

The Kaiser Family Foundation. (2005a). Idaho: Population Distribution by Insurance Status, state data 2002-03, U.S. 2003. Retrieved January 10, 2005 from <http://www.statehealthfacts.org/cgiin/healthfacts.cgi?action=profile&area=Idaho&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status>

The Kaiser Family Foundation. (2005b). Idaho Mandated Benefits, Private Insurers. Retrieved October 10, 2004 from <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>

Kost, K., Landry, D., and Darroch, J., (1998a). Predicting maternal behaviors during pregnancy: Does intention status matter? *Family Planning Perspectives* 30(2):79-88.

Kost, K.; Landry, D.; and Darroch, J. (1998b). The effects of pregnancy planning status on birth outcomes and infant care. *Family Planning Perspectives* 30(5):223-230,

March of Dimes. (2005a). Population of women 15-44 years by race/ethnicity: [Idaho, 2002](#). US Bureau of the Census. Population estimates for 1996-1999 and 2001-2002 are projected from the 2000 Census based on bridged race categories, released by the National Center for Health Statistics. Retrieved March 31, 2005, from [www.marchofdimes.com/peristats](http://www.marchofdimes.com/peristats).

March of Dimes. (2005b). Population of women 15-44 years: [Idaho, 2002](#). US Bureau of the Census. Population estimates for 1996-1999 and 2001-2002 are projected from the 2000 Census based on bridged race categories, released by the National Center for Health Statistics. Retrieved March 31, 2005, from [www.marchofdimes.com/peristats](http://www.marchofdimes.com/peristats).

March of Dimes. (2005c). Women 15-44 years below federal poverty level: [Idaho and US, 2000-2002 Average](#). US Bureau of the Census. Retrieved March 31, 2005, from [www.marchofdimes.com/peristats](http://www.marchofdimes.com/peristats).

Mental Health Program. (2004). Adult Mental Health Dashboard Report Fiscal Year 2004 Year-end. Boise, ID: Idaho Department of Health and Welfare.

National Campaign to Prevent Teen Pregnancy. (2004). Teen Pregnancy and Birth Rates in the United States. Retrieved on March 12, 2005 from <http://www.teenpregnancy.org/resources/data/pdf/stbyst03.pdf>

National Immunization Program. (2003). National Immunization Survey January 2002-December 2003. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services

Regier DA, Narrow WE, Rae DS, et al. (1993). The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50(2): 85-94.

Ross Products Division. (2003). Mothers Survey: Breastfeeding Trends Through 2002. Columbus, OH: Abbott Laboratories.

State of Idaho Substance Abuse Social Indicators. (2004). Substance Abuse Social Indicators. Retrieved December 12, 2004 from <http://www.class.uidaho.edu/sasi/>

Stohr, M. K., Vazquez, P.S., Valdon, Larinda, Wing, Jeneena, Smith-Daniels, Shellee, Elson, Robin, Floerchinger-Franks, Ginger, Aydelotte, James, Fellen, Sue, Green, David, Musser, Bill, (2003) Idaho Crime Victimization Survey – 2001. Idaho State Police.

Substance Abuse and Mental Health Services Administration. (2005) Substance Abuse Treatment Facility Locator. Retrieved January 10, 2005 from <http://findtreatment.samhsa.gov/>.

Maternal and Child Health Bureau. (2002). Women's Health USA 2002. Rockville, Maryland: U.S. Department of Health and Human Services, Health Resources and Services Administration.

Zuckerman S, McFeeters J, Cunningham P, Nichols L. (2004) Changes in medicaid physician fees, 1998-2003: implications for physician participation. *Health Aff (Millwood)*. 2004 Jan-Jun;Suppl Web Exclusives:W4-374-84.

## ***Chapter VI. Infants***

Barfield, W., Martin, J. and Hoyert, P. (2004). Racial/Ethnic Trends in Fetal Mortality- United States, 1990-2000. MMR 53(24):529-532. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Centers for Medicare & Medicaid. (2005). Annual EPSDT Participation Report [Idaho FY: 2003]. Form CMS-416. Baltimore, MD: U.S. Department of Health and Human Services.

Committee on Fetus and Newborn. (2004). Policy statement: Levels of neonatal care. *Pediatrics* 114(5): 1341-1347

Committee on Perinatal Health. (1976). Toward Improving the Outcome of Pregnancy: Recommendations far the Regional Development of Maternal and Perinatal Health Services. White Plains, NY: Match of Dimes National Foundation.

Cooke, R. (1987). Referral to a Regional Centre Improves Outcomes in Extremely Low Birthweight Infants. *Archives of Disease in Childhood* 62(6):619-21.

GrandsPlace. (2002). Idaho Grandparents and Other Relatives Raising Children: A State Fact Sheet. Retrieved April 1, 2005 from, <http://www.grandsplace.com/gp8/id.html>

Hamilton, B., Martin, J. and Sutton, P. (2004). Births: Preliminary Data for 2003. National Vital Statistics Report 53(9). Hyattsville, MD: National Center for Health Statistics.

Idaho Child Mortality Review Team. (2003). Child Deaths in Idaho: 2000. Boise, ID: Idaho Department of Health and Welfare, Division of Health.

Idaho Children's Trust Fund. (2004). Idaho Children's Trust Fund Annual Report, 2004. Retrieved April 1, 2005 from, <http://idahochildrenstrustfund.state.id.us/publications/ICTF%202004Annual%20Report.pdf>

Idaho Council for the Deaf and Hard-of-Hearing. (2004). Newborn Hearing Screening Program: Annual Reports 2001-2004. Unpublished data.

Idaho Department of Health and Welfare. (2001). 1999 PRATS (Pregnancy Risk Assessment Tracking System) Survey. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics.

Idaho Department of Health and Welfare. (2004a). Idaho Vital Statistics 2002. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Department of Health and Welfare. (2004b). Birth outcomes 2001-2003 stratified by race, age, county, etc. Boise, ID: Idaho Department of Health and Welfare, Bureau of Health Policy and Vital Statistics. Unpublished Data.

Idaho Department of Health and Welfare. (2005a). Number of Idaho Newborns Screened for Metabolic Conditions, Percent of Second Screens Performed and Number of Positive Results, 2002-2003. Boise, ID: Idaho Department of Health and Welfare, Bureau of Clinical Preventive Services. Unpublished data.

Idaho Department of Health and Welfare. (2005b). 2001 PRATS (Pregnancy Risk Assessment Tracking System) Survey. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Medicaid Office. (2004). Medicaid Eligibles and EPSDT Enrollment. Unpublished data.

Idaho Parents as Teachers. (2004). 2004 Annual Report. Retrieved April 1, 2005 from, <http://www.agls.uidaho.edu/idpat/docs/2004%20annual%20report.pdf>

Joint Committee on Infant Hearing. (2000). Year 2000 position statement: Principles & guidelines for early hearing detection & intervention programs. *Pediatrics* 106(4):798-817

Kaiser Family Foundation. (2005). Idaho: Births Financed by Medicaid as a Percent of Total Births, 2000. Retrieved March 31, 2005 from <http://statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Medicaid+%26+SCHIP&subcategory=Births+Financed+by+Medicaid&topic=As+Percent+of+State+Births>

March of Dimes. (2004a). Primary cesarean deliveries: Idaho and US, 1996-2002. Retrieved April 1, 2005 from, <http://www.marchofdimes.com/peristats/level1.aspx?reg=16&top=8&stop=87&lev=1&obj=1&sty=&eny=&slev=4&cmp=99&chy=>

March of Dimes. (2004b). Vaginal birth after cesarean deliveries: Idaho and US, 1996-2002. Retrieved April 1, 2005 from, <http://www.marchofdimes.com/peristats/level1.aspx?reg=16&top=8&stop=90&lev=1&obj=1&sty=&eny=&slev=4&cmp=99&chy=>

March of Dimes. (2004c). Preterm: Idaho and US, 1992-2002. Retrieved March 31, 2005 from, <http://www.marchofdimes.com/peristats/level1.aspx?reg=16&top=3&stop=60&lev=1&obj=1&sty=&eny=&slev=4&cmp=99&chy=>

March of Dimes. (2004d). Low birthweight: Idaho and US, 1992-2002. Retrieved March 31, 2005 from, <http://www.marchofdimes.com/peristats/level1.aspx?reg=16&top=4&stop=43&lev=1&obj=1&sty=&eny=&slev=4&cmp=99&chy=>

March of Dimes. (2004e). United States: Quick Facts- Birth Defects Overview. Retrieved April 1, 2005 from, <http://www.marchofdimes.com/peristats/tlanding.aspx?reg=99&top=16&lev=0&slev=1>

March of Dimes. (2004f). Infant deaths due to birth defects: Idaho and West, 1996-2001. Retrieved April 1, 2005 from, <http://www.marchofdimes.com/peristats/level1.aspx?reg=16&top=6&stop=109&lev=1&obj=1&sty=&eny=&slev=4&cmp=99040&chy=>

March of Dimes. (2005). Quick Reference: Low Birthweight. Retrieved April 1, 2005 from [http://www.marchofdimes.com/professionals/681\\_1153.asp](http://www.marchofdimes.com/professionals/681_1153.asp)

Martin, J., Hamilton, B., Sutton, P., Ventura, S., Menacker, F., and Munson, M. (2003). Births: Final Data for 2002. National Vital Statistics Report 52(10). Hyattsville, MD: National Center for Health Statistics.

McCormick, M., Shariro, S., and Stargfield, B. (1985). The Regionalization of Perinatal Services, Summary of the Evaluation of a National Demonstration Program. *JAMA* 253(6):799-804.

National Center for Health Statistics. (2004). Health, United States, 2004 With Chartbook on Trends in the Health of Americans. DHHS Publication No. 2004-1232. Hyattsville, MD: U.S. Department of Health and Human Services.

National Newborn Screening and Genetics Resource Center. (2005). U.S. National Screening Status Report- Updated 03/29/05. Retrieved April 1, 2005 from, <http://genes-r-us.uthscsa.edu/nbsdisorders.pdf>

National Research Council and Institute of Medicine. (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Committee on Integrating the Science of Early Childhood Development. Shonkoff, J. and Phillips, D., eds. Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

National Vaccine Program Office. (2001). Facts About SIDS. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved April 1, 2005 from, [http://www.hhs.gov/nvpo/factsheets/fs\\_tableVII\\_doc5.htm](http://www.hhs.gov/nvpo/factsheets/fs_tableVII_doc5.htm)

Parents Encouraging Parents. (2004). All About PEP. Accessed April 1, 2005 from, <http://www.parentingonline.org>

Sutton, S. and Mathews, T. (2004). Trends in Characteristics of Births by State: United States, 1990, 1995, and 2000-2002. National Vital Statistics Report (52)19. Hyattsville, MD: National Center for Health Statistics.

U.S. Department of Health and Human Services. (2000). Healthy People 2010: Understanding and Improving Health, 2nd ed. Washington, DC: U.S. Government Printing Office.

## ***Chapter VII: Children and Adolescents***

Action for Healthy Kids. (2002). Idaho State Profile. Retrieved March 29, 2005 from, <http://www.actionforhealthykids.org/docs/profiles/idaho.pdf>

Agency for Toxic Substances and Disease Registry. (2003). Health Consultation: Evaluation of Metals in Bullhead, Bass, and Kokanee from Lake Coeur D'Alene. Washington, DC: U.S. Department of Health and Human Services. Retrieved March 2, 2005 from, [http://www.atsdr.cdc.gov/HAC/PHA/coeurdalene/cda\\_toc.html](http://www.atsdr.cdc.gov/HAC/PHA/coeurdalene/cda_toc.html)

American Academy of Pediatrics. (1998). Screening for elevated blood lead levels. *Pediatrics*. 101(6):1072-1078

American Academy of Pediatrics. (2004). State Immunization Requirements for School Entry. Retrieved March 23, 2005 from, <http://www.sabin.org/pdf/immunization%20schedule%202004.pdf>

American Association of Child & Adolescent Psychiatry. (2004). Teenagers with Eating Disorders. Retrieved March 14, 2005, from <http://www.aacap.org/publications/factsfam/eating.htm>

American Association of Maternal and Child Health Care Program. (2004). Adolescent and School Health: Media Resource. Retrieved December 12, 2004 from, <http://www.amchp.org/policy/adolescent-id.htm>

American Council for Fitness and Nutrition. (2005). The State of Physical Activity and Nutrition Education in Idaho. Retrieved March 29, 2005 from, <http://www.acfn.org/resources/ID.pdf>

American Dental Association. (2004). Medicaid reimbursement for Mountain Region- Using marketplace principles to increase access to dental services. Retrieved January 24, 2005 from [http://www.ada.org/prof/advocacy/issues/medicaid\\_mountain.pdf](http://www.ada.org/prof/advocacy/issues/medicaid_mountain.pdf)

American Lung Association. (2004). Asthma & Children Fact Sheet. Retrieved January 24, 2005 from, <http://www.lungusa.org/site/pp.asp?c+dvLUK9O0E&b=44352>

American Obesity Association. (2004). Childhood Obesity: Prevalence and Identification. Retrieved January 5, 2005 from, <http://www.obesity.org/subs/chi;dhopod/prevalence.shtml>

Anderson, P., Butcher, K., and Levine, P. (2003). Economic perspectives on childhood obesity. *Economic Perspectives* 3Q:30-48

Barnett, W., Hustedt, J, Robin, K. and Schulman, K. (2004). The State of Preschool: 2004 State Preschool Yearbook. New Brunswick, NJ: National Institute for Early Education Research. Retrieved March 24, 2005 from, <http://nieer.org/yearbook/pdf/yearbook.pdf>

Boise School District. (2005). Welcome to Marion Pritchett High School: Our Services. Retrieved March 28, 2005 from, <http://www.sd01.k12.id.us/schools/booth/services.html>



Boonstra, H. (2004). Comprehensive approach needed to combat sexually transmitted infections among youth [Electronic version]. *The Guttmacher Report on Public Policy* 7(1). Retrieved January 10, 2005, from <http://www.agi-usa/pubs/tgr/07/1/gr070103.html>

Brenner, N., Eaton, D., Lowry, R., and McManus, T. (2004). The association between weight perception and BMI among high school students. *Obesity Research* 12(11):1866-1874

Bureau of Primary Health Care. (2004). Bureau of Primary Health Care Section 330 Grantees Uniform Data System (UDS): Calendar Year 2003 Data- Idaho Rollup Report. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration. Retrieved March 24, 2005 from, <http://bphc.hrsa.gov/uds/data.htm>

Burns, D., and Johnson, L. (2001). Overview of Recent Changes in Adolescent Smoking Behavior. In D. Burns, R. Amacher, W. Ruppert (Eds.) *Smoking and Tobacco Control Monograph 14: Changing Adolescent Smoking Prevalence, Where It Is and Why*, NIH Publication No. 02-5086, pp. 1-8. Washington, DC: U.S. Department of Health and Human Services, National Institutes of Health.

Centers for Disease Control and Prevention. (1996). Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 45(RR11):1-25. Atlanta, GA: U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. (2004). *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*. Atlanta, GA: U.S. Department of Health and Human Services.

Center for Law and Social Policy. (2004). Moving Forward: Head Start Children, Families, and Programs in 2003. Head Start Series, Brief No. 5. Retrieved March 24, 2005 from, [http://www.clasp.org/publications/hs\\_brf\\_5.pdf](http://www.clasp.org/publications/hs_brf_5.pdf)

Centers for Medicaid & Medicare Services. (2005a). Medicaid and EPSDT. Baltimore, MD: U.S. Department of Health and Human Services. Retrieved January 24, 2005 from, <http://www.cms.hhs.gov/medicaid/epsdt/default.asp>

Centers for Medicare & Medicaid. (2005b). Annual EPSDT Participation Report [Idaho FY: 2003]. Form CMS-416. Baltimore, MD: U.S. Department of Health and Human Services.

Centers for Medicare & Medicaid. (2001). Annual EPSDT Participation Report [Idaho FY: 1999]. Form CMS-416. Baltimore, MD: U.S. Department of Health and Human Services.

Children's Bureau. (2003). Final Report: Idaho Child and Family Services Review. Washington, DC: , U.S. Department of Health and Human Services, Administration for Children and Family Services.



Children's Bureau. (2004a). Child Welfare Outcomes 2001: Annual Report. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Family Services. Retrieved November 19, 2004, from

<http://www.acf.hhs.gov/programs/cb/publications/cwo01/statedata/id.htm>

Children's Bureau. (2004b). Child Maltreatment 2002. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Family Services. Retrieved November 19, 2004, from <http://www.acf.hhs.gov/programs/cb/publications/cm02/index.htm>

Child Care Bureau. (2004a). State Profiles: Idaho. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Family Services. Retrieved December 29, 2004, from the National Child Care Information Center Web site

<http://nccic.org/statedata/statepro/idaho.html>

Child Care Bureau. (2004b). Child Care and Development Funds. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Family Services. Retrieved August 12, 2004 from the National Child Care Information Center Web site

<http://128.174.128.220/cgi-bin/IMS/Search.asp>

Child Care Bureau. (2005). FFY 2003 CCDF Data Tables and Charts. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Family Services. Retrieved March 24, 2005 from,

<http://www.acf.hhs.gov/programs/ccb/research/03acf800/table4.htm>

Child Welfare League of America. (2003). Idaho's Children 2003. Retrieved December 20, 2004, from, <http://www.cwla.org/advocacy/statefactsheets/2003/idaho.pdf>

Dietz, W. (1998). Health consequences of obesity in youth: childhood predictors of adult disease. *Pediatrics* 101(3):518-525

Division of STD Prevention. (2004). Sexually Transmitted Disease Surveillance [Electronic version]. Atlanta, GA: Centers for Disease Control, U.S. Health and Human Services. Retrieved March 9, 2003, from <http://www.cdc.gov/std/stats/toc2003.htm>

Every Child by Age Two. (2005). The Immunization Issue. Retrieved January 24, 2005 from, <http://www.ecbt.org/issue.htm>

Fackler, A. (2004). Adolescent immunizations. Healthwise, Inc. Retrieved January 24, 2005 from, <http://www.healthwise.net/oregon/Content/StdDocument.aspx?DOCHWID=support-abouthw-kbnet>

Food & Nutrition Service. (2001). Foods Sold in Competition with USDA School Meal Programs: A Report to Congress". Washington, DC: U.S. Department of Agriculture. Retrieved March 29, 2005 from,

[http://www.fns.usda.gov/cnd/Lunch/CompetitiveFoods/report\\_congress.htm](http://www.fns.usda.gov/cnd/Lunch/CompetitiveFoods/report_congress.htm)

Friedman, M. (2005). Child Care. Almanac of Policy Issues. Retrieved January 24, 2005, from, [http://www.policyalmanac.org/social\\_welfare/childcare.shtml](http://www.policyalmanac.org/social_welfare/childcare.shtml)

Friends Committee on National Legislation. (2004). Friends of Indian Health Indian Fact Sheet. Retrieved January 25, 2005 from, [http://www.fcnl.org/issues/nat/sup/indians\\_healthfacts\\_41701.htm](http://www.fcnl.org/issues/nat/sup/indians_healthfacts_41701.htm)

Gish, M. (2003). Head Start Issues in the 108<sup>th</sup> Congress, Order Code RL30952. Washington, DC: U.S. Congress, Congressional Research Service, Domestic Social Policy Division. Retrieved March 24, 2005 from, <http://www.ilr.cornell.edu/library/downloads/keyWorkplaceDocuments/CRS/CRSHeadStart108.pdf>

Hawkins, D. and Prosper, M. (2004). . A Nation's Health at Risk, Special Topic Issue Brief #5. Washington, DC: National Association of Community Health Centers.

Hayes, L, Grunbaum, J., Kann, L., Hawkins, J., McManus, T., and Davis, K. (2004). School Health Profiles: Surveillance for Characteristics of Health Programs among Secondary Schools (Profiles 2002). Atlanta, GA: U.S. Health and Human Services, Centers for Disease Control and Prevention.

Idaho CareLine. (2005). Welcome to Community Resources Online. Retrieved March 28, 2005 from <http://www2.irissoft.com/uw10/>

Idaho Child Care Program. (2004). Children and families served FY2003-2004. Idaho Department of Health and Welfare. Unpublished data.

Idaho Child Mortality Review Team. (2003). Child Deaths in Idaho: 2000. Boise, ID: Idaho Department of Health and Welfare, Division of Health.

Idaho Children's Mental Health Program. (2001). Children's Mental Health Services: A Parent's Guide, Publication HW-0767. Boise, ID: Idaho Department of Health and Welfare, Division of Family and Community Services of Mental Health and Substance Abuse.

Idaho Children's Trust Fund. (2005). Idaho Children's Trust Fund 2004 Annual Report. [Electronic version]. Retrieved January, 2005 from <http://idahochildrenstrustfund.state.id.us/publications/ICTF%202004Annual%20Report.pdf>

Idaho Council on Children's Mental Health. (2004). Legislative Update. Retrieved March 31, 2005 from, <http://www.healthandwelfare.idaho.gov/Rainbow/Documents/health/cmhupdate.pdf>

Idaho Council on Domestic Violence & Crime Victim Assistance. (2003). Yearly Statistics Overview. Retrieved March 29, 2005 from, <http://www2.state.id.us/crimevictim/research/statistics/yearlystats.html>

Idaho Department of Education. (2003a). 2002 Idaho substance use, safety, and school climate survey [Electronic version]. Boise, ID. Retrieved November, 2005 from <http://www.sde.state.id.us/safe/docs/new/2002IdahoSubstanceUse-Safety-andSchoolClimateSurvey.pdf>

Idaho Department of Education. (2003b). A Healthy Look at Idaho Youth: Results of the 2003 Idaho Youth Risk Behavior Survey and 2002 School Health Education Profile. Boise, ID: Idaho Department of Education.

Idaho State Board of Education. (2003). Standards. Retrieved March 31, 2005 from, <http://boardofed.idaho.gov/saa/standards.asp>

Idaho Department of Education. (2004a). Number of students served by Special Education in Idaho during the 2002-2003 school year. Boise, ID: Idaho Department of Education, Bureau of Special Education. Unpublished data.

Idaho Department of Education. (2004b). Idaho Recommendations for Promoting a Healthy School Nutrition [Electronic version]. Boise, ID. Retrieved March 10, 2005 from <http://www.sde.state.id.us/child/docs/promotingahealthyschoolnutritionenvironment.pdf>

Idaho Department of Health and Welfare. (1997). Ceour D'Alene River Basin: Environmental Health Exposure Assessment- Summary Report [Electronic version]. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Community and Environmental Health. Retrieved March 17, 2005 from, [http://healthandwelfare.idaho.gov/Rainbow/Documents%5CHealth/cda\\_river\\_basin\\_exposure\\_summary\\_report.pdf](http://healthandwelfare.idaho.gov/Rainbow/Documents%5CHealth/cda_river_basin_exposure_summary_report.pdf)

Idaho Department of Health and Welfare. (1999). Idaho's Health: A Summary of Health Factors, Status, Systems, and Services. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics.

Idaho Department of Health and Welfare. (2001). Idaho Health and Safety Assessment. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics.

Idaho Department of Health and Welfare. (2002). Asthma in Idaho 2002. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Environmental Health and Safety.

Idaho Department of Health and Welfare. (2003a). Idaho Behavioral Risk Factors: Results From the 2002 Behavioral Risk Factor Surveillance System. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Department of Health and Welfare. (2003b). State of Idaho, Federal Community Mental Health Services Block Grant, Section IV, Idaho State Plan Implementation Report: Adult and children's mental health, FY 2003. Boise, ID: Idaho Department of Health and Welfare. Retrieved March 12, 2005 from, [http://www.healthandwelfare.idaho.gov/Rainbow/Documents%5CHealth/adult\\_child\\_implementation\\_plan\\_fy2003.pdf](http://www.healthandwelfare.idaho.gov/Rainbow/Documents%5CHealth/adult_child_implementation_plan_fy2003.pdf)

Idaho Department of Health and Welfare. (2004a). Access Card/CHIP-B Programs. Retrieved December 4, 2004 from,

[http://www.healthandwelfare.idaho.gov/portal/alias\\_Rainbow/lang\\_en-US/tabID\\_3351/DesktopDefault.aspx?alias=Rainbow&lang=en-US&tabID=3351](http://www.healthandwelfare.idaho.gov/portal/alias_Rainbow/lang_en-US/tabID_3351/DesktopDefault.aspx?alias=Rainbow&lang=en-US&tabID=3351)

Idaho Department of Health and Welfare. (2004b). Idaho's suicide prevention plan [Electronic version]. Boise, ID: Idaho Department of Health and Welfare. Retrieved March 16, 2005 from, [http://www.healthandwelfare.idaho.gov/Rainbow/Documents/Health/suicide\\_plan.pdf](http://www.healthandwelfare.idaho.gov/Rainbow/Documents/Health/suicide_plan.pdf)

Idaho Department of Health and Welfare. (2004c). Idaho Mental Health Professional Shortage Area Service Areas. Boise, ID: Idaho Department of Health and Welfare, Office of Rural Health and Primary Care. Unpublished data.

Idaho Department of Health and Welfare. (2004d). Idaho reportable disease list. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Epidemiology. Retrieved March 23, 2005 from <http://www.healthandwelfare.idaho.gov/Rainbow/Documents/health/REPORTDisease%20Poster%20Oct%202004.pdf>

Idaho Department of Health and Welfare. (2004e). Reported diseases/conditions in 2003 by sex, age group, and race/ethnicity, Idaho. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Epidemiology. Unpublished data.

Idaho Department of Health and Welfare. (2004f). State reported causes of herpes. University of Idaho, Substance Abuse Social Indicators. Retrieved December 19, 2004 from, [http://www.class.uidaho.edu/sasi/State\\_Totals\\_files/State.STDs/state\\_herpes.htm](http://www.class.uidaho.edu/sasi/State_Totals_files/State.STDs/state_herpes.htm)

Idaho Department of Health and Welfare. (2004g). Idaho Vital Statistics 2002. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Health Policy and Vital Statistics.

Idaho Department of Health and Welfare. (2004h). Performance improvement project focus groups: Executive summary. Boise ID, Idaho Department of Health and Welfare, Division of Health, Regional Directors.

Idaho Department of Health and Welfare. (2005a). Idaho Foster Care and Adoption Programs: Fostering Idaho's Future. Retrieved March 28, 2005 from [http://www.healthandwelfare.idaho.gov/portal/alias\\_Rainbow/lang\\_en-US/tabID\\_3334/DesktopDefault.aspx?alias=Rainbow&lang=en-US&tabID=3334](http://www.healthandwelfare.idaho.gov/portal/alias_Rainbow/lang_en-US/tabID_3334/DesktopDefault.aspx?alias=Rainbow&lang=en-US&tabID=3334)

Idaho Department of Health and Welfare. (2005b). Unintentional Injury Program. Retrieved March 29, 2005 from, [http://www.healthandwelfare.idaho.gov/portal/alias\\_Rainbow/lang\\_en-US/tabID\\_3516/DesktopDefault.aspx](http://www.healthandwelfare.idaho.gov/portal/alias_Rainbow/lang_en-US/tabID_3516/DesktopDefault.aspx)

Idaho Department of Health and Welfare. (2005c). Sexual Violence Prevention. Retrieved March 29, 2005 from, <http://www.healthandwelfare.idaho.gov/DesktopModules/Articles/ArticlesView.aspx?TabID=0&Alias=Rainbow&Lang=en-US&ItemID=1123&mid=10596>

Idaho Department of Health and Welfare. (2005d). Child Care Licensing. Retrieved March 24, 2005, from, <http://www.healthandwelfare.idaho.gov/DesktopModules/ArticlesSortable/ArticlesSrtView.aspx?tabID=0&alias=Rainbow&lang=en-US&ItemID=350&mid=10420>

Idaho Department of Health and Welfare. (2005e). Elevated blood lead levels, Idaho, 2002-2003, by health district. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Community and Environmental Health. Unpublished data.

Idaho Head Start Association. (2003). Executive summary of Idaho Head Start data, Eighth Edition. Boise, ID: Idaho Head Start Association.

Idaho Head Start Association. (2004). Summary 2003- Idaho Head Start Program information report. Boise, ID. Unpublished data.

Idaho Immunization Program. (2004). IRIS Enrollment 1997-2003. Boise, ID: Idaho Department of Health and Welfare, Bureau of Clinical Preventive Services. Unpublished data.

Idaho Kids Count. (2003). 2003 State Data Book. Boise, ID: Mountain States Group, Inc.

Idaho Medicaid Office. (2004). Medicaid Eligibles and EPSDT Enrollment. Unpublished data.

Idaho Oral Health Program. (2001). Idaho Oral Health Summit 2001: Summit Report. Boise, ID: Department of Health and Welfare, Division of Health, Bureau of Community and Environmental Health.

Idaho Oral Health Program. (2002). Idaho Oral Health Plan 2002-2005. Boise, ID: Department of Health and Welfare, Division of Health, Bureau of Community and Environmental Health.

Idaho Oral Health Program. (2003). 2001 Idaho Smile Survey: Data Summary. Boise, ID: Department of Health and Welfare, Division of Health, Bureau of Community and Environmental Health.

Idaho Oral Health Program. (2004). 2003 School Fluoride Mouthrinse Program: Cost Savings. Boise, ID: Department of Health and Welfare, Division of Health, Bureau of Community and Environmental Health. Retrieved March 16, 2005 from, [http://www.healthandwelfare.idaho.gov/Rainbow/Documents%5Chealth/cost\\_savings\\_school\\_fluoride\\_mouthrinse\\_program.pdf](http://www.healthandwelfare.idaho.gov/Rainbow/Documents%5Chealth/cost_savings_school_fluoride_mouthrinse_program.pdf)

IDHW Oral Health Program. (2005). Oral health. Boise, ID: Department of Health and Welfare, Division of Health, Bureau of Community and Environmental Health. Retrieved March 16, 2005 from, <http://www.healthandwelfare.idaho.gov/DesktopModules/ArticlesSortable/ArticlesSrtView.aspx?tabID=0&alias=Rainbow&lang=en-US&ItemID=435&mid=10560>

Idaho Reproductive Health Program. (2005). Reproductive Health (Family Planning). Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical Preventive Services. Retrieved March 28, 2005 from,

[http://www.healthandwelfare.idaho.gov/portal/alias\\_Rainbow/lang\\_en-US/tabID\\_3388/DesktopDefault.aspx](http://www.healthandwelfare.idaho.gov/portal/alias_Rainbow/lang_en-US/tabID_3388/DesktopDefault.aspx)

Idaho STD/AIDS Program. (2003). Idaho 2002 Sexually Transmitted Disease Facts Book. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical Preventive Services. Retrieved March 28, 2005 from [http://www.healthandwelfare.idaho.gov/\\_Rainbow/Documents/health/facts\\_book\\_2002.pdf](http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/health/facts_book_2002.pdf)

Idaho WIC Program. (2002). Nutrition Surveillance Report of the Idaho WIC Program. IDHW. Boise, ID: Department of Health and Welfare, Division of Health, Bureau of Clinical Preventive Services.

Idaho WIC Program. (2005). Prevalence of overweight among WIC children. Boise, ID: Department of Health and Welfare, Division of Health, Bureau of Clinical Preventive Services. Unpublished data.

IdahoSTARS. (2005). About us. Retrieved March 24, 2005 from, <http://idahostars.org/about/about.html>

Joyce, E. (2004). Teen dating violence: Facing the epidemic. *Networks (National Center for Victims of Crime)* 19(1): 1-9

Kaiser Family Foundation. (2005a). Idaho: Distribution of Children 18 and Under by Insurance Status, state data 2002-2003, U.S. 2003. Retrieved March 31, 2005 from, <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status&topic=Distribution+of+Children+18+and+Under>

Kaiser Family Foundation. (2005b). Idaho: Distribution of Children 18 and Under by Insurance Status, state data 2002-2003, U.S. 2003. Retrieved March 31, 2005 from, <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Idaho&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status&topic=Distribution+of+Children+18+and+Under>

Kaiser Family Foundation. (2005c). Percent of Private Sector Establishments That Offer Health Insurance to Employees, 2002. [http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=Managed+Care+%26+Health+Insurance&subcategory=&topic=&link\\_category=Health+Coverage+%26+Uninsured&link\\_subcategory=Private+Sector+Coverage&link\\_topic=Percent+of+Firms+Offering+Coverage&welcome=0&area=Idaho](http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=Managed+Care+%26+Health+Insurance&subcategory=&topic=&link_category=Health+Coverage+%26+Uninsured&link_subcategory=Private+Sector+Coverage&link_topic=Percent+of+Firms+Offering+Coverage&welcome=0&area=Idaho)

Kochanek, K., Murphy, S., Anderson, R., and Scott, C. (2004). Deaths: Final Data for 2002. National Vital Statistics Reports, 53(5). Hyattsville, MD: National Center for Health Statistics.

Leatherman, S. and McCarthy, D. (2004). "Quality of Health Care for Children and Adolescents: A Chartbook". UNC-Chapel Hill. Retrieved February 10, 2005 from, <http://www.sph.unc.edu/health-outcomes/chartbook/pedschartbook.htm>



Lourie, I. and Davis, C. (1999). A needs assessment of Idaho's children with serious emotional disturbances and their families. Washington, DC: Partners Human Services Collaborative.

Lyall, K. (1995). Binge Drinking in College: A Definitive Study In Binge Drinking on American College Campuses: A New Look at an Old Problem. Princeton, NJ: Robert Wood Johnson Foundation.

Mason, K. (2003). Healthy Child Care Idaho. HRSA 03-055 Transitioning Health Child Care America 2000, Grant No. 1 H24 MC 00087-01. Idaho Association for the Education of Young Children.

National Center for Chronic Disease Prevention and Health Promotion. (2001). School Health Policies and Programs Study (SHPPS) 2000: A summary report. *Journal of School Health* 71(7):251-350

National Center for Chronic Disease Prevention and Health Promotion. (2003). National diabetes fact sheet. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved March 23, 2005 from [http://www.cdc.gov/diabetes/pubs/pdf/ndfs\\_2003.pdf](http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2003.pdf)

National Center for Chronic Disease Prevention and Health Promotion. (2005a). 5 a Day. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved March 14, 2005, from <http://www.cdc.gov/nccdphp/dnpa/5aday/>

National Center for Chronic Disease Prevention and Health Promotion. (2005b). Bone Health. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved March 14, 2005, from <http://www.cdc.gov/nccdphp/dnpa/bonehealth/index.htm>

National Center for Chronic Disease Prevention and Health Promotion. (2005c). Oral Health Resource. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved March 16, 2005 from <http://www2.cdc.gov/nccdphp/doh/synopses/StateDataV.asp?StateID=ID&Year=2004>

National Center for Chronic Disease Prevention and Health Promotion. (2004). YRBS- Youth Online: Comprehensive Results. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved November 12, 2004 from, <http://apps.nccd.cdc.gov/yrbss/>

National Center for Environmental Health. (1997). Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control. Retrieved March 17, 2005 from, <http://www.cdc.gov/nceh/lead/guide/guide97.htm>

National Immunization Program. (2003). National Immunization Survey January 2002-December 2003. Atlanta, GA: : U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Olbrich, S. (2002). Children's mental health: Current challenges and a future direction. Center for Health and Health Care in Schools. Retrieved March 14, 2005 from, <http://www.healthinschools.org/mhs2.asp>

Oral Health America. (2004). The Oral Health America National Grading Project 2003. Retrieved January 24, 2005 from, <http://www.oralhealthamerica.org/pdf/2003ReportCard.pdf>

National Assembly on School-Based Health Care. (2003). School-Based, Linked and Mobile Health Centers: May, 2003. Retrieved March 27, 2005 from <http://www.nasbhc.org/EQ/2001census/Mapbystate.pdf>

National Association of Rural Health Clinics. (2005). About Us. Retrieved March 18, 2005 from, [http://www.narhc.org/about\\_us/about\\_us.php?PHPSESSID=5e05094b9c67d6288a81fc11e2638550](http://www.narhc.org/about_us/about_us.php?PHPSESSID=5e05094b9c67d6288a81fc11e2638550)

National Association of State Boards of Education. (2005). State-Level School Health Policies: Idaho. Retrieved March 16, 2005 from, <http://www.nasbe.org/HealthySchools/States/Idaho.html>

National Center for Children in Poverty. (2005). CCDF Subsidies, Participants and Spending". Retrieved March 8, 2005 from, [http://www.nccp.org/policy\\_cross\\_state.html](http://www.nccp.org/policy_cross_state.html)

National Conference of State Legislatures. (2004). Providing Reproductive Health Services for Adolescents: State Options. Retrieved January 10, 2005, from <http://www.ncsl.org/programs/health/forum/pub6768.htm>

National Immunization Program. (2005). A Parent's Guide to Childhood Immunization. Retrieved January 24, 2005 from, <http://www.cdc.gov/nip/publications/Parents-Guide/default.htm>

NHLBI Communications Office. (2004). Average Blood Pressure Levels on Rise Among American Children/Teenagers. NIH News, May 4, 2004. Washington, DC: National Heart, Lung, and Blood Institute. Retrieved March 29, 2005 from, <http://www.nhlbi.nih.gov/new/press/04-05-04.htm>

Perkins, J. (1999). Fact sheet: Early and Periodic Screening, Diagnosis, and Treatment. National Health Law Program. Retrieved January 24, 2005 from, <http://www.healthlaw.org/pubs/199990323epsdtfact.html>

Rocchini, A. (2002). Childhood obesity and a diabetes epidemic. *New England Journal of Medicine* 346(11):8554-8555

Scheiman, L. and Zeoli, A. (2003). Adolescents' experiences of dating and intimate partner violence: "Once is not enough". *Journal of Midwifery & Women's Health* 48(3):226-228.

Shanahan, T. (2003). Fact Sheet: The Facts About Foster Care. Boise, ID: Idaho Department of Health and Welfare, Office of the Director. Retrieved March 30, 2005 from, [http://www.healthandwelfare.idaho.gov/Rainbow/Documents%5Cchildren/foster\\_kid\\_facts\\_english.pdf](http://www.healthandwelfare.idaho.gov/Rainbow/Documents%5Cchildren/foster_kid_facts_english.pdf)



Starfield, B. and Shi, L. (2004). The medical home, access to care, and insurance: A review of evidence. *Pediatrics* 113(5 Suppl.):1493-1498

Statistical Analysis Center. (2003). Intimate Partner Violence: A NIBRS Analysis. Meridian, ID: Idaho State Police.

Substance Abuse and Mental Health Services Administration. (2003). Child and Adolescent Mental Health, DHHS Publication No. CA-0004. Washington, DC: U.S. Department of Health and Human Services. Retrieved March 30, 2005 from <http://www.mentalhealth.samhsa.gov/publications/allpubs/CA-0004/default.asp>

Substance Abuse Social Indicators. (2004). State of Idaho Substance Abuse Social Indicators Web Page. Retrieved December 12, 2004 from <http://www.class.uidaho.edu/sasi/>

Suicide Prevention Resource Center. (2004). Idaho Suicide Prevention Fact Sheet [Electronic version]. Retrieved March 16, 2005 from, [http://www.sprc.org/statepages/factsheets/id\\_datasheet.pdf](http://www.sprc.org/statepages/factsheets/id_datasheet.pdf)

U.S. Census Bureau. (2001). Census 2000 Summary File 1 [Idaho]. Washington, DC: U.S. Department of Commerce.

U.S. Census Bureau. (2004). Estimates of the Total Resident Population and Resident Population Age 18 Years and Older for the United States and States: July 1, 2004. Washington, DC: U.S. Department of Commerce.

U.S. Center on an Aging Society. (2002). Childhood obesity: A lifelong threat to health. *Challenges for the 21st Century: Chronic and Disabling Conditions* 2:2-5. Retrieved March 29, 2005 from, <http://ihcrp.georgetown.edu/agingsociety/pdfs/obesity.pdf>

U.S. Department of Health and Human Services. (2000). Healthy People 2010: Understanding and Improving Health, 2nd ed. Washington, DC: U.S. Government Printing Office.

## **Chapter VIII: CSHCN**

Bureau of Special Education (Unknown). 2003-2004 Special Education Data Report: STATE Report. Idaho Department of Education. Retrieved March 31, 2005 from <http://www.sde.state.id.us/specialed/DDR/ddranalysis.asp>

Bureau of Special Education. (Unknown B). Part B Annual Performance Report 2002-2003. Idaho Department of Education. Retrieved March 31, 2005 from <http://www.sde.state.id.us/specialed/docs/partbannualperformance.pdf>

Bureau of Special Education. (2004). Number of Students Served by Special Education in Idaho During the 2003-2004 school year. Idaho Department of Education. Unpublished Data.

Center on Disabilities and Human Development. (2004). *Promoting Inclusive Child Care in Idaho*. Paper prepared for the Idaho Department of Health and Welfare, Division of Medicaid. September 2004.

Early Intervention Research Institute. (2001). What is a Community to Do? Helping Families Help Their Children with Special Needs. Opening Doors Into Rural Communities Web Cast. Early Intervention Research Institute. Retrieved November 14, 2004 from [http://eiri.usu.edu/projects/odrc/ODRCWebCast\\_Handouts.pdf](http://eiri.usu.edu/projects/odrc/ODRCWebCast_Handouts.pdf)

Idaho Children's Special Health Program. (2004). Program Data. Boise, ID: Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical and Preventive Services. Unpublished.

Idaho Infant Toddler Program. (2004). Infant Toddler Program June 1, '04 Status. Boise, ID: Idaho Department of Health and Welfare, Division of Family and Community Services.

Idaho Legislative Services Office. (2001). Idaho Fiscal Facts, 2001. Retrieved March 31, 2005 from <http://www.legislature.idaho.gov/Budget/Publications.htm>

Idaho Legislative Services Office. (2004). Idaho Fiscal Facts, 2004. Retrieved March 31, 2005 from <http://www.legislature.idaho.gov/Budget/Publications.htm>

Maternal and Child Health Bureau. (2004). The National Survey of Children with Special Health Care Needs Chartbook 2001. Rockville, Maryland: U.S. Department of Health and Human Services, Health Resources and Services Administration, 2004.

Maternal and Child Health Bureau. (2005). National Performance Measures. Retrieved January 3, 2005 from <https://performance.hrsa.gov/mchb/mchreports/Search/core/corsch01p.asp>

McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck P, Perrin J, Shonkoff J, and Strickland B. (1998). A new definition of children with special health care needs. *Pediatrics* 1998;102(1):137-140.

Office of Special Education Programs. (2004). Table AA10, Percentage (Based on 2003 Population Estimates) of Children Served Under IDEA, Part B By Age Group, In 2003. ALL DISABILITIES. U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS) Retrieved March 31, 2005 from [http://www.ideadata.org/tables27th/ar\\_aa10.htm](http://www.ideadata.org/tables27th/ar_aa10.htm)

## ***Appendix E: Performance Measures***

---

### **Overview**

Performance and outcome measures were introduced in 1999 by the MCHB in response to the Government Performance and Results Act (GPRA) of 1993. The purpose of GPRA is "to improve federal program effectiveness and public accountability by promoting a focus on results, service quality and customer satisfaction." Performance measures are tied to a performance-based program budget, and the states are accountable for meeting the performance measures and evaluating their results in all federally funded programs. Use of performance measures is a good public health practice and was also recommended by the Institute of Medicine in its two studies of the status of public health in America. GPRA also requires comprehensive strategic plans, annual performance plans with measurable goals and objectives, and annual reports on actual performance compared to performance goals.

The MCHB guidance fulfills all of the requirements of GPRA and assures that the states meet those requirements through the MCH Block Grant application and annual report. However, the performance and outcome measures are not a comprehensive representation of the entire scope of the Title V program within any given state. The national performance and outcome measures were selected because they are common to all Title V programs, they relate to existing data sources, and the program results can be quantified or measured. The state negotiated performance and outcome measures allow the state to address its unique needs that surface as a result of the needs assessment. A priority in one state may not be a priority in another state; allowing states to negotiate additional performance and outcome measures ensures flexibility. There are a number of systems building activities that the block grant conducts that are difficult to measure - the quality and extent of interagency collaboration, for example. Because the application limits the number of performance and outcome measures that can be submitted, there will always be state programs that will not be identified in the application.

States ensure public accountability in the block grant in three ways: by annually measuring progress toward performance measures, by budgeting and reporting funds, and by improving MCH outcome measures. The guidance requires reporting on the MCH populations served and the activities provided by level of the MCH pyramid for each of the 18 national performance measures, as well as the 7-10 state negotiated performance measures. The outcome measures should improve over time if the performance measures and the activities to accomplish the measures were adequate. Providing this information publicly demands that the state collect

dependable service-level data. For public accountability, the State must describe their accomplishments, current activities, plans for the coming year and the populations served. The table below summarizes Idaho's performance based on these measures.

Performance Measure	Indicator	Data Sources
<b>Pregnant Women</b>		
<i>MCHB National Measures:</i>		
<ul style="list-style-type: none"> <li>The rate of birth (per 1,000) for teenagers aged 15 through 17 years (PM #08)</li> </ul>	18.3 per 1,000 (average 2001-2003)	<ul style="list-style-type: none"> <li>IDHW, Bureau of Health Policy and Vital Statistics</li> </ul>
<ul style="list-style-type: none"> <li>Percent of very low -birth-weight infants delivered at facilities for high-risk deliveries and neonates (PM #17)</li> </ul>	Not Available	<ul style="list-style-type: none"> <li>Not Available</li> </ul>
<ul style="list-style-type: none"> <li>Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. (PM #18)</li> </ul>	81.7% (Average 2001-2003)	<ul style="list-style-type: none"> <li>Idaho Vital Statistics</li> <li>PRATS 2001</li> </ul>
<i>ID State Measures:</i>		
<ul style="list-style-type: none"> <li>Proportion of all pregnancies seen in Reproductive Health clinics that are unintended. (State PM #1)</li> </ul>	62.1% of women who went to the District Health Office (RH Clinic) for any service, and who were pregnant, did not plan their pregnancy.	<ul style="list-style-type: none"> <li>Family Planning/Reproductive Health Program, IDHW</li> <li>Guttmacher Institute</li> </ul>
<ul style="list-style-type: none"> <li>Percent of positive pregnancy tests in Reproductive Health Program participants younger than 20 years old (State PM #2)</li> </ul>	5.7% of positive pregnancy tests in Reproductive Health program participants of less than 20 years old	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>
<b>Mothers</b>		
<i>MCHB National Measures:</i>		
<ul style="list-style-type: none"> <li>Percentage of mothers who breastfeed their infants at hospital discharge (PM #11)</li> </ul>	87.6% of Idaho mothers initiated breastfeeding at the hospital 79% of WIC Clients initiated breastfeeding	<ul style="list-style-type: none"> <li>Ross Mothers Survey</li> <li>PRATS</li> <li>National Immunization Survey</li> <li>WIC</li> </ul>

Performance Measure	Indicator	Data Sources
<b>Infants</b>		
<i>MCHB National Measures:</i>		
<ul style="list-style-type: none"> <li>The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State. (PM #01)</li> </ul>	95% of screened newborns with confirmed metabolic conditions were followed up in 2003	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>
<ul style="list-style-type: none"> <li>Percentage of newborns who have been screened for hearing before hospital discharge (PM #12)</li> </ul>	97% of newborns were screened for hearing before hospital discharge in 2003	<ul style="list-style-type: none"> <li>Newborn Hearing Screening Program</li> </ul>
<ul style="list-style-type: none"> <li>Percent of very low birth weight infants among all live births (PM #15)</li> </ul>	1% of infants were of very low birthweight during 2001-2003	<ul style="list-style-type: none"> <li>IDHW, Bureau of Health Policy and Vital Statistics</li> </ul>
<i>ID State Measures:</i>		
<ul style="list-style-type: none"> <li>Percent of infant deaths attributed to SIDS that are autopsied. (State PM #8)</li> </ul>	100% of infant deaths attributed to SIDS were autopsied in 2003	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>
<b>Children and Adolescents</b>		
<i>MCHB National Measures:</i>		
<ul style="list-style-type: none"> <li>Percent of third grade children who have received protective sealants on at least one permanent molar tooth. (PM #09)</li> </ul>	53.6% third graders received dental sealants in 2001	<ul style="list-style-type: none"> <li>Idaho State Smile Survey</li> </ul>
<ul style="list-style-type: none"> <li>Percentage of children without health insurance (PM #13)</li> </ul>	14% of children under age 18 were uninsured during 2002-2003	<ul style="list-style-type: none"> <li>Kaiser Family Foundation</li> </ul>
<ul style="list-style-type: none"> <li>Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B. (PM #07)</li> </ul>	78% of children ages 19-35 months were up-to-date on the 4:3:1:3:3 immunization series in 2003	<ul style="list-style-type: none"> <li>National Immunization Survey</li> </ul>

Performance Measure	Indicator	Data Sources
<ul style="list-style-type: none"> <li>Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program (PM #14)</li> </ul>	94.3% of children ages 1-21 of eligible children received services paid by Medicaid in 2003	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>
<ul style="list-style-type: none"> <li>The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. (PM #10)</li> </ul>	5.89 deaths per 100,000 children ages 0-14 in 2002	<ul style="list-style-type: none"> <li>Idaho 2002 Vital Statistics Report</li> </ul>
<ul style="list-style-type: none"> <li>The rate (per 100,000) of suicide deaths among youths 15–19. (PM #16)</li> </ul>	13.68 deaths per 100,000 children ages 15-19 in 2002	<ul style="list-style-type: none"> <li>Idaho 2002 Vital Statistics Report</li> </ul>
<i>ID State Measures:</i>		
<ul style="list-style-type: none"> <li>Use of the Idaho CareLine as a clearinghouse (information/referral service) of information for non-health related children's social and developmental services (State PM #3)</li> </ul>	13,719 calls in 2000	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>
<ul style="list-style-type: none"> <li>Rate of child deaths reviewed by the ID Child Mortality Review Team (State PM #4)</li> </ul>	50.2% of deaths to children under age 18 were reviewed by the Child Mortality Review Team	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>
<ul style="list-style-type: none"> <li>Doses of hepatitis A vaccine administered to children at kindergarten entry (State PM #5)</li> </ul>	16,971 doses of hepatitis A vaccine were administered in 2003	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>
<ul style="list-style-type: none"> <li>Percent of children age 5 years who are caries-free in their primary teeth (have no decayed, missing or filled teeth due to tooth decay) (State PM #6)</li> </ul>	53.6% of kindergarten children were caries-free in 2001	<ul style="list-style-type: none"> <li>Idaho State Smile Survey</li> </ul>
<ul style="list-style-type: none"> <li>Percent of investigations completed for children with elevated blood lead levels (State PM #7)</li> </ul>	100% of investigations of children with elevated blood lead levels were completed in 2003	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>
<ul style="list-style-type: none"> <li>Percentage of CHIP-eligible children who are enrolled in the program (State PM #9)</li> </ul>	41% of eligible children were enrolled in CHIP in 2003	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>

Performance Measure	Indicator	Data Sources
<b>Children with Special Health Care Needs</b>		
<i>MCHB National Measures:</i>		
<ul style="list-style-type: none"> <li>The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey) (PM #02)</li> </ul>	57% of families of CSHCN partner in decision making <u>and</u> are satisfied with services 90% say doctors usually or always make the family feel like a partner 58% report being very satisfied with the services they receive	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> <li>CDC 2003</li> </ul>
<ul style="list-style-type: none"> <li>The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey) (PM #03)</li> </ul>	49% of CSHCN families report receiving coordinated, ongoing, comprehensive care within a medical home	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>
<ul style="list-style-type: none"> <li>The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey) (PM #04)</li> </ul>	53% of families of CSHCN report having adequate private and/or public insurance to pay for the services they need	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>
<ul style="list-style-type: none"> <li>Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey) (PM #05)</li> </ul>	75% of families of CSHCN report that community-based service systems are organized so they can use them easily.	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>
<ul style="list-style-type: none"> <li>The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey) (PM #06)</li> </ul>	6% of families of CSHCN report receiving the services needed to make transition to all aspects of adult life	<ul style="list-style-type: none"> <li>Idaho MCH Title V block grant</li> </ul>



## ***Appendix F: Capacity***

---

The following table describes the capacity of Idaho BOCAPS and partners to address each of the outcomes. Sample capacity indicators and examples of activities to increase that capacity were identified.

<b>Table VI</b> <b>ID Summary of Relationships of MCH Outcomes and Activities</b>			
Outcome	Capacity Indicator	Capacity	Examples of Current Activities
<b>1. Pregnant Women</b>			
<ul style="list-style-type: none"> <li>Women of childbearing age appropriately use ongoing preventive and primary care.</li> </ul>	<ul style="list-style-type: none"> <li>% of Women ages 18-64 that are uninsured</li> </ul>	<ul style="list-style-type: none"> <li>36.9% of Low-income Women are uninsured (2001-2002)</li> <li>20.1% of all Women are uninsured (2001-2002)</li> </ul>	None Identified
	<ul style="list-style-type: none"> <li># and dist of family planning clinics serving teens and low-income</li> </ul>	69 throughout State (2001)	Family Planning/Reproductive Health Program, BOCAPS
	<ul style="list-style-type: none"> <li>% of Births that are unintended</li> </ul>	37% of Idaho Resident Adult Mothers (3-12 months postpartum) indicated their pregnancy was unintended (2001)	<ul style="list-style-type: none"> <li>Family Planning/ Reproductive Health Program, BOCAPS</li> <li>PRATS Surveillance System</li> </ul>
	<ul style="list-style-type: none"> <li>State guidelines for coverage of family planning services under Medicaid</li> </ul>	Not Mandated	BOCAPS working with partners to pass this legislation
	<ul style="list-style-type: none"> <li>% of women who need subsidized family planning services receive them</li> </ul>	50% of women in need of publicly funded contraceptive services and supplies were served (2001)	Family Planning/Reproductive Health Program, BOCAPS
	% receiving annual dental care	33.8% of adults had not visited a dentist with the previous 12 months (2003)	Oral Health Program
	Prevalence and treatment of Depression	37.2% of women ages 18-44 thought they may have depression, and 23.6% of pregnant women. (2001)	Adult Mental Health Services Parents as Teachers and other parent-support initiatives
	Breast cancer screening	67% of women ages 40 years+ received a mammogram within the previous 2 years (2002)	Women's Health Check Family Planning/Reproductive Health
	<ul style="list-style-type: none"> <li>Cervical cancer screening</li> </ul>	83.4% of women reported receiving a pap test in the last 3 years (2002)	Women's Health Check Family Planning/Reproductive Health
<ul style="list-style-type: none"> <li>Pregnant women use early and adequate</li> </ul>	<ul style="list-style-type: none"> <li>% of infants born to 1<sup>st</sup> trimester care mothers</li> </ul>	81.7% (Average 2001-2003)	Education through WIC, Family Planning, Prenatal Ancillary Program (in 1 District), hospital-based initiatives

**Table VI**  
**ID Summary of Relationships of MCH Outcomes and Activities**

Outcome	Capacity Indicator	Capacity	Examples of Current Activities
prenatal care.	<ul style="list-style-type: none"> <li>Barriers to accessing PNC</li> </ul>	Reasons for not receiving care as early as desired: unaware of the pregnancy (30.2%), not able to obtain an appointment earlier (28.3%), lacked money or insurance (28.1%), didn't have a Medicaid care (17.0%) or the doctor would not start care earlier (12.3%). (2001)	Some District Health Offices have prenatal care initiatives linking women who come for a pregnancy test to PNC.
	<ul style="list-style-type: none"> <li>% of pregnant Medicaid-eligible women enrolled</li> </ul>	Unknown	Presumptive Eligibility Determination
	<ul style="list-style-type: none"> <li>% of mothers reporting screening for DV</li> </ul>	6.5% of mothers reported that they were physically abused during the 12 month period before pregnancy. 4.2% reported that they were physically abused during pregnancy. (2001)	<ul style="list-style-type: none"> <li>PRATS Surveillance System</li> <li>Sexual Violence Prevention activities</li> <li>Idaho Police Surveys and Surveillance</li> <li>Idaho Council on Domestic Violence funds 26 projects throughout Idaho</li> </ul>
	<ul style="list-style-type: none"> <li>Perception of discrimination by prenatal health care providers based on race/ethnicity</li> </ul>	Focus group participants in two studies cited discrimination based on race/ethnicity	<ul style="list-style-type: none"> <li>Hispanic Issues Training Conference</li> <li>Idaho PCA training and outreach</li> <li>The Hispanic Health Projects, Idaho State University</li> </ul>
	<ul style="list-style-type: none"> <li>% of mothers reporting HIV testing during pregnancy</li> </ul>	49.0% of Idaho resident adult mothers indicated that they were tested for HIV during their pregnancy. (2001)	<ul style="list-style-type: none"> <li>PRATS Surveillance System</li> <li>Idaho Perinatal Conference Presentation and Booth</li> <li>Idaho STD/AIDS program plans to develop an HIV tracking system</li> </ul>
<ul style="list-style-type: none"> <li>Pregnant women use as appropriate the full range of enabling and support services to promote a positive pregnancy outcome.</li> </ul>	<ul style="list-style-type: none"> <li>% use of WIC</li> <li>parenting education</li> </ul>	<p>34% of pregnant women were enrolled in WIC (2001)</p> <p>Small numbers of pregnant women served through Baby Steps, Early Head Start</p>	<ul style="list-style-type: none"> <li>WIC</li> <li>Baby Steps</li> <li>Early Head Start</li> <li>Hospital-based prenatal classes</li> </ul>

<b>Table VI</b> <b>ID Summary of Relationships of MCH Outcomes and Activities</b>			
Outcome	Capacity Indicator	Capacity	Examples of Current Activities
<b>2. Mothers</b>			
<ul style="list-style-type: none"> <li>Mothers use comprehensive post-partum services and ongoing primary care.</li> </ul>	<ul style="list-style-type: none"> <li># and distribution of mental health care providers trained to serve postpartum women</li> </ul>	<ul style="list-style-type: none"> <li>Every county in Idaho is classified as a Mental Health Professional Shortage Area (2004)</li> <li>9 Hospitals have postpartum depression support groups (2004)</li> </ul>	Study being done by Boise State University's College of Education PPD Advisory Group
	<ul style="list-style-type: none"> <li>Medicaid coverage of PPD</li> </ul>	Variable	Unknown
<ul style="list-style-type: none"> <li>Mothers use as appropriate the enabling and support services needed by them and their families to care for their infants and children.</li> </ul>	<b>See Infant Outcomes</b>		
<ul style="list-style-type: none"> <li>Mothers have access to breastfeeding information and support as needed.</li> </ul>	% initiating breastfeeding % exclusively breastfeeding at 3 months % breastfeeding at 6-months	<ul style="list-style-type: none"> <li>87.6% of Idaho mothers initiated breastfeeding at the hospital, and 46.2% were breastfeeding at 6 months postpartum (2002)</li> <li>55.7% (+6.0) of women reported exclusively breastfeeding at 3 months(2003)</li> </ul>	<ul style="list-style-type: none"> <li>WIC</li> <li>La Leche league</li> <li>Idaho Breastfeeding Coalition</li> </ul>
<b>3. Infants</b>			
<ul style="list-style-type: none"> <li>Infants are born at term, normal weight and without preventable congenital defects.</li> </ul>	Rate of cesarean deliveries % of lowbirth weight births	21.2 (2003) 6.4% all races and ethnic groups (2000-2003) <ul style="list-style-type: none"> <li>10.2 Black infants</li> <li>6.7 Hispanic infants</li> <li>6.5 Asian infants</li> <li>6.4 White infants</li> <li>5.9 American Indian infants</li> </ul>	ID Perinatal Project Community/Migrant Health Centers Tribal Health Services

**Table VI**  
**ID Summary of Relationships of MCH Outcomes and Activities**

Outcome	Capacity Indicator	Capacity	Examples of Current Activities
	% premature births	10.4% all races and ethnic groups <ul style="list-style-type: none"> <li>11.7 American Indian infants</li> <li>11.6 Black infants</li> <li>11.3 Hispanic infants</li> <li>10.3 Asian</li> <li>10.3 White</li> </ul>	
	Infant mortality rate	6.6 all races and ethnic groups (2000-2002) <ul style="list-style-type: none"> <li>8.8 Hispanic infants</li> </ul>	
	Neonatal mortality rate	4.5 all races and ethnic groups (2000-2002) <ul style="list-style-type: none"> <li>6.8 Hispanic</li> </ul>	
	% of infant deaths due to birth defects	30.7% (2002)	
	Rate of deaths attributed to SIDS	62.0 (2002)	
	# of perinatal providers	<ul style="list-style-type: none"> <li>12% of non-Federal primary care physicians are ObGYNs (n=129) (2003)</li> <li>161 physicians per 100,000 resident population (2002)</li> </ul>	Idaho Perinatal Project
	% of newborns who received hearing screening before hospital discharge	97% of newborns born in a hospital were screened for hearing hospital discharge (2003) 34 of 35 hospitals participate in screening	<ul style="list-style-type: none"> <li>Newborn Hearing Screening Program/Idaho Sound Beginnings</li> <li>Infant/Toddler Program</li> </ul>
	% of newborns who received at least one screening for each of the metabolic conditions	At least 97% of newborns were screened for metabolic conditions (2003)	<ul style="list-style-type: none"> <li>Newborn Screening Program</li> <li>Newborn Screening Taskforce (MoD, Idaho Hospital Association, BOCAPS, Medicaid, etc)</li> </ul>
	% infants with positive newborn screening test results who received confirmatory testing and were referred for follow-up treatment as needed	<ul style="list-style-type: none"> <li>Hearing Screening: 54% (2003)</li> <li>Metabolic Screening: 76% (2003)</li> </ul>	
	% VLBW/preterm babies born at facilities equipped to care for them	Unknown	
<ul style="list-style-type: none"> <li>Very low birthweight/preterm babies are born in facilities equipped to care for them</li> </ul>	# and distribution of birthing facilities including NICUs	<ul style="list-style-type: none"> <li>6 NICUs (3 Level III, 3 Level II) (2004)</li> <li>23 Counties with no short-term OB Beds (2000)</li> <li>8 Counties have 78% of all short-term OB Beds (2000)</li> </ul>	

**Table VI**  
**ID Summary of Relationships of MCH Outcomes and Activities**

Outcome	Capacity Indicator	Capacity	Examples of Current Activities
	% of Infants referred to community support programs	Approx 25% of mothers whose baby was admitted to a NICU reported being told about community support programs like the Infant Toddler or CSHP (1999)	Infant Toddler Program
	% MUAs and HPSAs designations	<ul style="list-style-type: none"> <li>68% of Idaho's counties had at least one area with a MUA/MUP designation (2004)</li> <li>84% of Idaho counties have a primary care HPSA designation (2004)</li> </ul>	<ul style="list-style-type: none"> <li>Federally Qualified Health Centers</li> <li>Rural Health Centers</li> <li>Tribal Health Services</li> </ul>
<ul style="list-style-type: none"> <li>Infants are welcomed into a family, a home, and a community that is prepared to care for them.</li> </ul>	# of parenting education services by type and geographic reach	<ul style="list-style-type: none"> <li>44 Parents as Teacher programs served 1,756 families (2003-2004). <ul style="list-style-type: none"> <li>Parents significantly increased the amount they read to children</li> <li>Almost all children screened for development, hearing and vision</li> </ul> </li> <li>Total number served through parenting education and their geographic location are unknown</li> </ul>	<ul style="list-style-type: none"> <li>Children's Trust Fund</li> <li>PAT</li> <li>Parents Encouraging Parents</li> <li>Early Head Start</li> </ul>
	TANF enrollment of eligible families	<ul style="list-style-type: none"> <li>Monthly family cap of \$309 regardless of the number of persons in the household (2002)</li> <li>5 percent of low-income children in Idaho receive TANF, compared to 12 percent nationally (2004)</li> </ul>	
	% of families that are food insecure	<ul style="list-style-type: none"> <li>13.7 % of households were identified as food insecure (with or without hunger) (2002)</li> </ul>	<ul style="list-style-type: none"> <li>Food Stamp Program</li> <li>WIC</li> </ul>
	% of families that are housing burdened	38.3% of households paid more than 30% (and 15.5% paid more than 50%) of their incomes toward housing as of April 2000.	<ul style="list-style-type: none"> <li>LIHEAP</li> <li>Section 8</li> </ul>
<ul style="list-style-type: none"> <li>Infants appropriately receive ongoing preventive and primary care.</li> </ul>	% of eligible infants enrolled in Medicaid or SCHIP	Unknown	<ul style="list-style-type: none"> <li>Idaho Covering Kids and Families</li> <li>Idaho CareLine</li> </ul>
	% of Medicaid enrollees receiving at least one initial periodic screen	<ul style="list-style-type: none"> <li>56% of enrolled infants received at least one screening (FFY 03)</li> <li>48% of the expected number of initial or periodic screenings were actually conducted (FFY 03)</li> </ul>	<ul style="list-style-type: none"> <li>Healthy Connections</li> <li>Infant Toddler Program</li> </ul>

**Table VI**  
**ID Summary of Relationships of MCH Outcomes and Activities**

Outcome	Capacity Indicator	Capacity	Examples of Current Activities
<b>4. Children</b>			
<ul style="list-style-type: none"> <li>Children receive ongoing and preventive health care consistent with the Bright Futures Health Supervision Guidelines.</li> </ul>	<ul style="list-style-type: none"> <li>% uninsured children eligible for public insurance</li> </ul>	<ul style="list-style-type: none"> <li>40% children under age 18 eligible for Medicaid/CHIP (2002)</li> </ul>	<ul style="list-style-type: none"> <li>CHIP-B and Access Card Program</li> </ul>
	<ul style="list-style-type: none"> <li>EPSDT participant ratio</li> </ul>	<ul style="list-style-type: none"> <li>0.30 among ages 1-20 in (2003)</li> </ul>	
	% children up-to-date on immunizations	<ul style="list-style-type: none"> <li>83% children ages 19-35 months had basic vaccine coverage (2003)</li> <li>61% children ages 19-35 months had complete vaccine coverage (2003)</li> </ul>	<ul style="list-style-type: none"> <li>94% of all children under age 2 enrolled in IRIS</li> </ul>
	<ul style="list-style-type: none"> <li>% schools that identify and track students with asthma</li> <li>% schools that used an Asthma Action Plans</li> </ul>	55% schools identifies and tracked asthma students (2001) 29% schools used Asthma Action Plans (2001)	<ul style="list-style-type: none"> <li>Statewide asthma needs assessment in 2002</li> </ul>
	% overweight children	<ul style="list-style-type: none"> <li>11.8% WIC children ages 2-5 overweight (2003)</li> <li>7.4% of children in grades 9-12 overweight (2003)</li> </ul>	<ul style="list-style-type: none"> <li>Idaho Recommendations for Promoting a Healthy School Nutrition Environment</li> </ul>
	<ul style="list-style-type: none"> <li>% children with dental caries</li> <li>% children with untreated tooth decay</li> </ul>	<ul style="list-style-type: none"> <li>66% of 3rd graders had dental caries (2001)</li> <li>27% of 3rd graders had untreated tooth decay (2001)</li> </ul>	<ul style="list-style-type: none"> <li>State Oral Health Plan developed for 2002-2005</li> </ul>
<ul style="list-style-type: none"> <li>Children are cared for in environments that protect their health, promote their wellbeing and ensure their safety</li> </ul>	<ul style="list-style-type: none"> <li>% children with serious emotional disturbance (SED)</li> <li>% adolescents that attempted suicide</li> </ul>	<ul style="list-style-type: none"> <li>4% 21 years and younger estimated to have SED (1998)</li> <li>9% of adolescents in grades 9-12 attempted suicide (2003)</li> </ul>	<ul style="list-style-type: none"> <li>Conducted statewide needs assessment of children with SED in 1998</li> <li>Established Idaho Council on</li> <li>Developed State Suicide Plan in 2004</li> </ul>
	Number of children with Idaho Child Care Program (ICCP) subsidies % ICCP children served in unregulated settings	9,413 children in ICCP during FY2004 45% ICCP children served in unregulated settings (2001)	<ul style="list-style-type: none"> <li>Idaho State Training and Registry System (IdahoSTARS)</li> </ul>
	% 3-4-year olds enrolled in school % eligible 3-4-year olds enrolled in Head Start	<ul style="list-style-type: none"> <li>37% 3-4-year olds enrolled in school (2000)</li> <li>44% eligible 3-4-year olds enrolled in Head Start during 2002-2003</li> </ul>	<ul style="list-style-type: none"> <li>Idaho legislature added 188 new Head Start enrollment slots in 1999</li> </ul>

**Table VI**  
**ID Summary of Relationships of MCH Outcomes and Activities**

Outcome	Capacity Indicator	Capacity	Examples of Current Activities
	<ul style="list-style-type: none"> <li>State health services coordinator for all schools?</li> <li>% schools with school-based health centers (SBHC)</li> <li>Nurse-to-student ratio</li> </ul>	<ul style="list-style-type: none"> <li>No state health services coordinator</li> <li>0% schools with SBHCs</li> <li>1:950 estimated nurse-to-student ratio in 2004</li> </ul>	<ul style="list-style-type: none"> <li>School Nurse Organization of Idaho</li> </ul>
	<ul style="list-style-type: none"> <li>Child maltreatment victimization rate</li> <li>Child maltreatment fatality rate</li> </ul>	<ul style="list-style-type: none"> <li>5.3 victims per 1,000 (2002)</li> <li>0.54 deaths per 100,00 (2002)</li> </ul>	<ul style="list-style-type: none"> <li>Child Welfare Performance Improvement Project Focus Groups conducted by IDHW Regional Directors in 2004</li> </ul>
	<ul style="list-style-type: none"> <li>% children with elevated blood lead levels</li> </ul>	<ul style="list-style-type: none"> <li>2% children ages 0-6 “inside the box” within the Coeur d’Alene River Basin</li> <li>4% children ages 0-9 “outside the box” within the Coeur d’Alene River Basin</li> <li>2.8 µg/dL “inside the box”</li> <li>3.2 µg/dL “outside the box”</li> </ul>	<ul style="list-style-type: none"> <li>Continued clean up of Coeur d’Alene River Basin waste sites</li> </ul>
	<ul style="list-style-type: none"> <li>Mean blood lead level</li> <li>All-cause mortality rates</li> </ul>	<ul style="list-style-type: none"> <li>28.0 deaths per 100,000 children ages 1-4</li> <li>17.5 deaths per 100,000 children ages 5-14</li> <li>73.9 deaths per 100,000 children ages 15-19</li> </ul>	<ul style="list-style-type: none"> <li>SAFE KIDS Coalitions in Idaho have helped provide education materials and distribute injury prevention devices such as bicycle helmets</li> </ul>
<ul style="list-style-type: none"> <li>Families have access to and appropriately use services that strengthen their parenting skills</li> </ul>	See infant outcomes		
<ul style="list-style-type: none"> <li>Adolescent children use ongoing health services appropriate to their stage and growth and development.</li> </ul>	<ul style="list-style-type: none"> <li>High school dropout rate</li> <li>% young adults that complete high school</li> </ul>	<ul style="list-style-type: none"> <li>5% in 1999-2000</li> <li>74.7% of adults ages 18-24 completed high school in 2000</li> </ul>	Safe and Drug-Free Schools Program activities help prevent school dropout
	<ul style="list-style-type: none"> <li>% adolescents who ever had sex</li> <li>adolescent STI rate</li> </ul>	<ul style="list-style-type: none"> <li>26.4% of adolescents in grades 9-12 ever had sex (2003)</li> <li>8.7 adolescents ages 15-19 with STIs per 100,000 (2002)</li> </ul>	<ul style="list-style-type: none"> <li>Idaho STD/AIDS Program</li> <li>Idaho Reproductive Health Program</li> </ul>



**Table VI**  
**ID Summary of Relationships of MCH Outcomes and Activities**

Outcome	Capacity Indicator	Capacity	Examples of Current Activities
	<ul style="list-style-type: none"> <li>% adolescents that smoke cigarettes</li> <li>% adolescents that drank alcohol</li> <li>% adolescents that used illicit drugs</li> </ul>	<ul style="list-style-type: none"> <li>17.8% of adolescents in grades 9-12 smoked cigarettes in past month (2003)</li> <li>34.8% of adolescents in grades 9-12 drank alcohol in past month (2003)</li> <li>30.6% of adolescents in grades 9-12 ever used marijuana (2003)</li> <li>5.0% of adolescents in grades 9-12 ever used cocaine (2003)</li> <li>5.6% of adolescents in grades 9-12 ever used methamphetamines (2003)</li> </ul>	IDHW Substance Abuse Program
	<ul style="list-style-type: none"> <li>% adolescents that engaged in motor vehicle crash related risk behaviors</li> </ul>	<ul style="list-style-type: none"> <li>9.6% of adolescents in grades 9-12 drove while intoxicated (2003)</li> <li>24.1% of adolescents in grades 9-12 rode with an intoxicated driver (2003)</li> <li>11.0% of adolescents in grades 9-12 rarely or never wore seatbelts (2003)</li> </ul>	<ul style="list-style-type: none"> <li>Idaho Department of Transportation's teen driver website, <a href="http://www.xtra4.com">www.xtra4.com</a></li> </ul>
	<ul style="list-style-type: none"> <li>% adolescents who have been victims of intimate partner violence</li> </ul>	<ul style="list-style-type: none"> <li>11.2% of adolescents in grades 9-12 were physically abused by an intimate partner (2003)</li> <li>9.6% of adolescents in grades 9-12 were sexually abused by an intimate partner (2003)</li> </ul>	<ul style="list-style-type: none"> <li>IDHW's Sexual Violence Prevention Program</li> <li>Idaho Council on Domestic Violence and Crime Victim Assistance</li> </ul>
	<ul style="list-style-type: none"> <li>% adolescents that engaged in physical fighting</li> <li>% adolescents that carried a weapon to school</li> <li>% adolescents that belong to gangs</li> </ul>	<ul style="list-style-type: none"> <li>11.7% adolescents in grades 9-12 engaged in physical fighting in 2003</li> <li>7.7% of adolescents in grades 9-12 carried a weapon to school in 2003</li> <li>4% of 6th graders belonged to gangs in 2002</li> <li>8% of 10th graders belonged to gangs in 2002</li> </ul>	<ul style="list-style-type: none"> <li>Idaho State Department of Education's Safe and Drug-Free Schools Program</li> </ul>
<ul style="list-style-type: none"> <li>Adolescent children obtain the health and lifestyle information and education that support life-long</li> </ul>	<ul style="list-style-type: none"> <li>% schools that require health education courses</li> <li>State health education coordinator?</li> </ul>	<ul style="list-style-type: none"> <li>49% of schools in grades 6-12 required at least one health education course in 2002</li> <li>There is a state health education coordinator</li> </ul>	

**Table VI**  
**ID Summary of Relationships of MCH Outcomes and Activities**

Outcome	Capacity Indicator	Capacity	Examples of Current Activities
positive health behaviors.	<ul style="list-style-type: none"> <li>% teachers in grades 6-12 that tried to increase student knowledge about sexual risk behaviors in required health education courses</li> <li>% teachers that received recent staff development training about sexual risk behaviors for required health education courses</li> </ul>	<ul style="list-style-type: none"> <li>87% taught human sexuality in 2002</li> <li>79% taught pregnancy prevention in 2002</li> <li>92% taught STD prevention in 2002</li> <li>96% taught HIV prevention in 2002</li> <li>26% received recent human sexuality training in 2002</li> <li>16% received recent pregnancy prevention training in 2002</li> <li>41% received recent STD prevention training in 2002</li> <li>54% received recent HIV prevention training in 2002</li> </ul>	<ul style="list-style-type: none"> <li>Idaho Governor's Council on Adolescent Pregnancy Prevention (IGCAPP)</li> </ul>
	<ul style="list-style-type: none"> <li>% teachers in grades 6-12 that tried to increase student knowledge about nutrition and physical activity risk behaviors in required health education courses</li> <li>% teachers that received recent staff development training about nutrition and physical activity risk behaviors for required health education courses</li> </ul>	<ul style="list-style-type: none"> <li>99% taught nutrition and dietary behavior in 2002</li> <li>99% taught physical activity and fitness in 2002</li> <li>24% received recent nutrition and dietary behavior training in 2002</li> <li>32% received recent physical activity and fitness training in 2002</li> </ul>	<ul style="list-style-type: none"> <li>Idaho Recommendations for Promoting a Healthy School Nutrition Environment</li> </ul>
	<ul style="list-style-type: none"> <li>% teachers in grades 6-12 that tried to increase student knowledge about substance use risk behaviors in required health education courses</li> <li>% teachers that received recent staff development training about substance use risk behaviors for required health education courses</li> <li>% adolescent smokers that tried to quit</li> </ul>	<ul style="list-style-type: none"> <li>99% taught tobacco use prevention in 2002</li> <li>99% taught alcohol/drug use prevention in 2002</li> <li>30% received recent tobacco use prevention training in 2002</li> <li>47% received recent alcohol/drug use prevention in 2002 training</li> <li>53% of current adolescent smokers in grades 9-12 tried to quit smoking in 2003</li> </ul>	<ul style="list-style-type: none"> <li>IDHW Tobacco Program's Project Filter</li> </ul>

**Table VI**  
**ID Summary of Relationships of MCH Outcomes and Activities**

Outcome	Capacity Indicator	Capacity	Examples of Current Activities
	<ul style="list-style-type: none"> <li>% teachers in grades 6-12 that tried to increase student knowledge about injury risk behaviors in required health education courses</li> <li>% teachers that received recent staff development training about injury risk behaviors for required health education courses</li> </ul>	<ul style="list-style-type: none"> <li>94% taught accident or injury prevention in 2002</li> <li>97% taught emotional and mental health in 2002</li> <li>85% taught suicide prevention in 2002</li> <li>83% taught violence prevention in 2002</li> <li>26% received recent accident or injury prevention training in 2002</li> <li>26% received recent emotional and mental health prevention training in 2002</li> <li>21% received recent suicide prevention training in 2002</li> <li>45% received recent violence prevention training in 2002</li> </ul>	<ul style="list-style-type: none"> <li>SAFE KIDS Coalitions in Idaho have used training grants to provide injury prevention education to children and families</li> <li>Idaho State Department of Education's Safe and Drug-Free Schools Program</li> </ul>
<b>5. CSHCN</b>			
<ul style="list-style-type: none"> <li>Children with a chronic health problem or disabling conditions use all the <b>primary and preventive services</b> needed by typical children.</li> </ul>	% of CSHCN needing routine preventive care	64.7% of families reported that their CSHCN needed routine preventive care, such as a physical examination or well-child check-up in 2001 White (66.5) vs Hispanic (52.2) Ages 0-5 (80.5) vs Ages 6-11 (59.9)	<ul style="list-style-type: none"> <li>Healthy Connections, Medicaid managed care program, increases contact with primary care providers.</li> </ul>
	Of those who need preventive care, % that receive it	95.4% of families reported that they were able to obtain preventive care when needed (2001) 66.9% of those who could not obtain care because it cost too much (2001)	<ul style="list-style-type: none"> <li>Expansion of Community Health Centers.</li> </ul>
	% of CSHCN who need dental care	82.9% of families reported that their CSHCN needed dental care (2001) White (83.8) vs Hispanic (68.5) Private Insurance(86.8) vs Uninsured (72.5)	Expansion of Community Health Centers, including some with dental clinics.
	Of those who need dental care, % that receive it	88.5% of families reported that they were able to obtain dental care (2001)	

**Table VI**  
**ID Summary of Relationships of MCH Outcomes and Activities**

Outcome	Capacity Indicator	Capacity	Examples of Current Activities
<ul style="list-style-type: none"> <li>CSHCN use the full range of health and health-related services needed to maintain or improve their health and wellbeing and the services to slow, delay, or prevent untoward outcomes resulting from their chronic health condition or disability.</li> </ul>	Types of specialty care that are difficult to access	<p>For most types of care, families reported being able to receive it for their CSHCN(2001):</p> <p>25% of families who reported needing mental health care or counseling for their CSHCN were unable to receive it</p> <p>23% of families who reported needing genetic counseling for their CSHCN were unable to receive it</p> <p>Cost was #1 reason for inability to obtain care necessary, but varied across types of care</p>	<ul style="list-style-type: none"> <li>Idaho Council on Children's Mental Health</li> <li>Medicaid and Special Education have partnered to increase number of schools receiving Medicaid reimbursements for Special Education services.</li> </ul>
	% of families of CSHCN reporting problems obtaining referrals for needed specialty care	17.9% of families reported a problem getting a referral to see a specialist (2001)	<ul style="list-style-type: none"> <li>Medicaid care coordination services</li> <li>Infant Toddler Program</li> </ul>
	# and geographic distribution of rehabilitative service providers for children	The majority of therapists are located in urban centers	<ul style="list-style-type: none"> <li>Idaho Council on Children's Mental Health (Regional and community councils)</li> </ul>
	Degree to which the State CSHCN Program provides or finances specialty and subspecialty care, not otherwise accessible or affordable to its clients	Significant changes in the program. Approximately 300 uninsured children will be served in 2005.	<ul style="list-style-type: none"> <li>CSHP continues to finance services for uninsured children.</li> </ul>
	% of CSHCN who receive coordinated, ongoing comprehensive care within a medical home(% unmet need for care coordination, % have personal doctor or nurse; % have a usual source of sick care)	<p>90.2% of CSHCN has a usual source of care</p> <p>87.6% of CSHCN has a personal doctor or nurse who knows them well</p> <p>48.3% of parents of CSHCN stated that doctors communicated well with each other</p> <p>37.1% of parents of CSHCN reported that doctors communicated well with other programs</p> <p>Those with private insurance less likely to receive care coordination than those with public insurance (23.5% vs 40.5%)</p>	<p>CSHP</p> <p>Infant Toddler Program</p> <p>Medicaid Care Coordinators</p>

**Table VI**  
**ID Summary of Relationships of MCH Outcomes and Activities**

Outcome	Capacity Indicator	Capacity	Examples of Current Activities
<ul style="list-style-type: none"> <li>Families of CSHCN, including their siblings, have access to and use appropriately the full range of health and health-related services required to promote their growth and wellbeing and manage their condition or disability.</li> </ul>	% of CSHCN who are uninsured	6.2% of CSHCN are uninsured, 18% of Hispanic CSHCN are uninsured (2001) 12.5% of CSHCN had a gap in health coverage during the year prior to the interview(2001) 84.2% of families reported that insurance usually or always met their child's need	Katie Beckett Medicaid Medicaid/SCHIP CSHP
	% of families of CSHCN reporting receiving family-centered care	Parents of CSHCN reported: <ul style="list-style-type: none"> <li>84.4% of doctors usually or always spent enough time</li> <li>87.0% of doctors usually or always listened carefully</li> <li>85.9% of doctors were usually or always sensitive to values and customs</li> <li>80.5% of doctors usually or always provided needed information</li> </ul>	<ul style="list-style-type: none"> <li>St. Luke's Care Coordination and parent support groups</li> <li>Infant Toddler Program</li> </ul>
<ul style="list-style-type: none"> <li>CSHCN use out-of-home childcare, pre-school and ongoing educational services as appropriate to their age, developmental stage and health condition and/or disability.</li> </ul>	% of childcare slots available for CSHCN	Exact % unknown, IDHW reports that it is very limited	<ul style="list-style-type: none"> <li>Medicaid supported "Developmental Disabilities Agency Provider" (but usually not in child care setting)</li> <li>Task force developed to discuss options for increasing access</li> </ul>
	% of children screened and determined eligible for publicly finances EI services who receive them	Approx 5,500 ASQ's sent by mail in 2004. Regional variation in screening initiatives Regional variation in enrollment (2004) 1.53% of 0-1 pop 2.49% of 0-3 pop	<ul style="list-style-type: none"> <li>Infant Toddler Program</li> <li>Head Start</li> <li>District Health Offices</li> </ul>

**Table VI**  
**ID Summary of Relationships of MCH Outcomes and Activities**

Outcome	Capacity Indicator	Capacity	Examples of Current Activities
	Availability of transition services to school and from school to adult life	<ul style="list-style-type: none"> <li>Only 11 children leaving the IT program were not assessed for special education services in 2002-2003.</li> <li>% of Special Education students employed one year after graduation has decreased by almost 10% in two years to 58.5% in the graduating class of 2002</li> <li>28.4% of parents reported that there is a plan for addressing their child's changing needs (over the age of 13) (2001)</li> <li>19.6% of CSCHN over the age of 13 have received vocational or career training (2001)</li> </ul>	<ul style="list-style-type: none"> <li>Special Education Program and Infant Toddler Program</li> <li>Idaho Interagency Council</li> <li>IPUL</li> </ul>